STATE OF LOUISIANA
LEGISLATIVE FISCAL OFFICE
BATON ROUGE

John D. Carpenter
Legislative Fiscal Officer

Post Office Box 44097
Capitol Station
Baton Rouge, Louisiana 70804
Phone: 225.342.7233
Fax: 225.342.7243

TO: The Honorable James R. Fannin, Chairman Joint Legislative Committee on the Budget (JLCB)
The Honorable Jack Donahue, Vice Chairman Joint Legislative Committee on the Budget (JLCB)
Honorable Members of the Joint Legislative Committee on the Budget (JLCB)

FROM: J. Travis McIlwain, Section Director
John D. Carpenter, Legislative Fiscal Officer

DATE: March 20, 2015

SUBJECT: Office of Group Benefits (OGB) Update (March 2015)

Graph 1 below depicts the OGB Fund Balance History from FY 08 to FY 14 along with the ending balance for the months of July 2014 through February 2015 (FY 15). During the month of February, OGB's fund balance gained approximately $3 M, or a positive 3% fund balance change.

Since the beginning of FY 15, OGB's expenditures have been approximately $101.6 M more than actual revenue collections through February 2015. This has resulted in the OGB fund balance decreasing from $207 M (beginning of FY 15) to $105.9 M (through February 2015). The decrease equates to an updated FY 15 monthly burn rate of approximately $12.7 M per month, which equates to a decrease from the January 2015 monthly burn rate of $14.9 M per month. OGB's cash on hand through February 2015 is approximately $180 M. Table 1 below portrays the monthly OGB fund balance impact in FY 15.

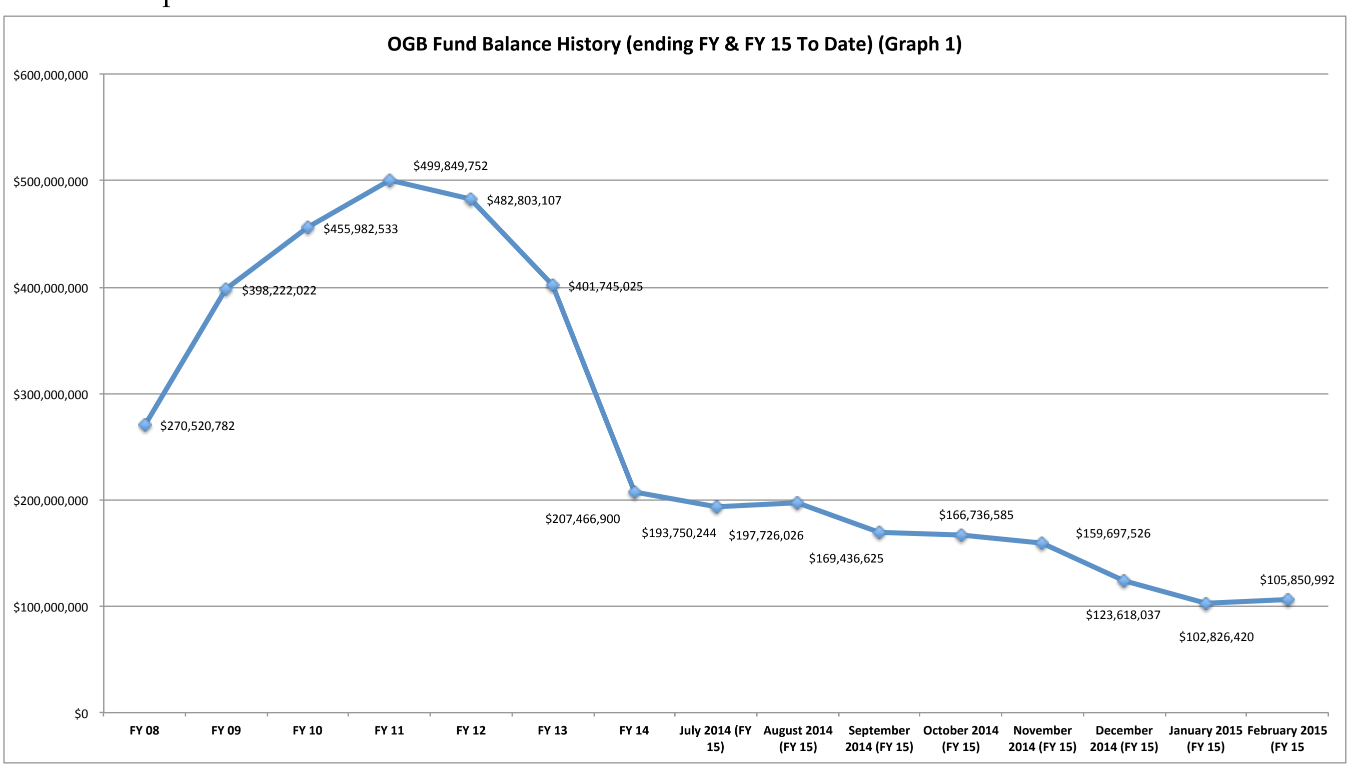
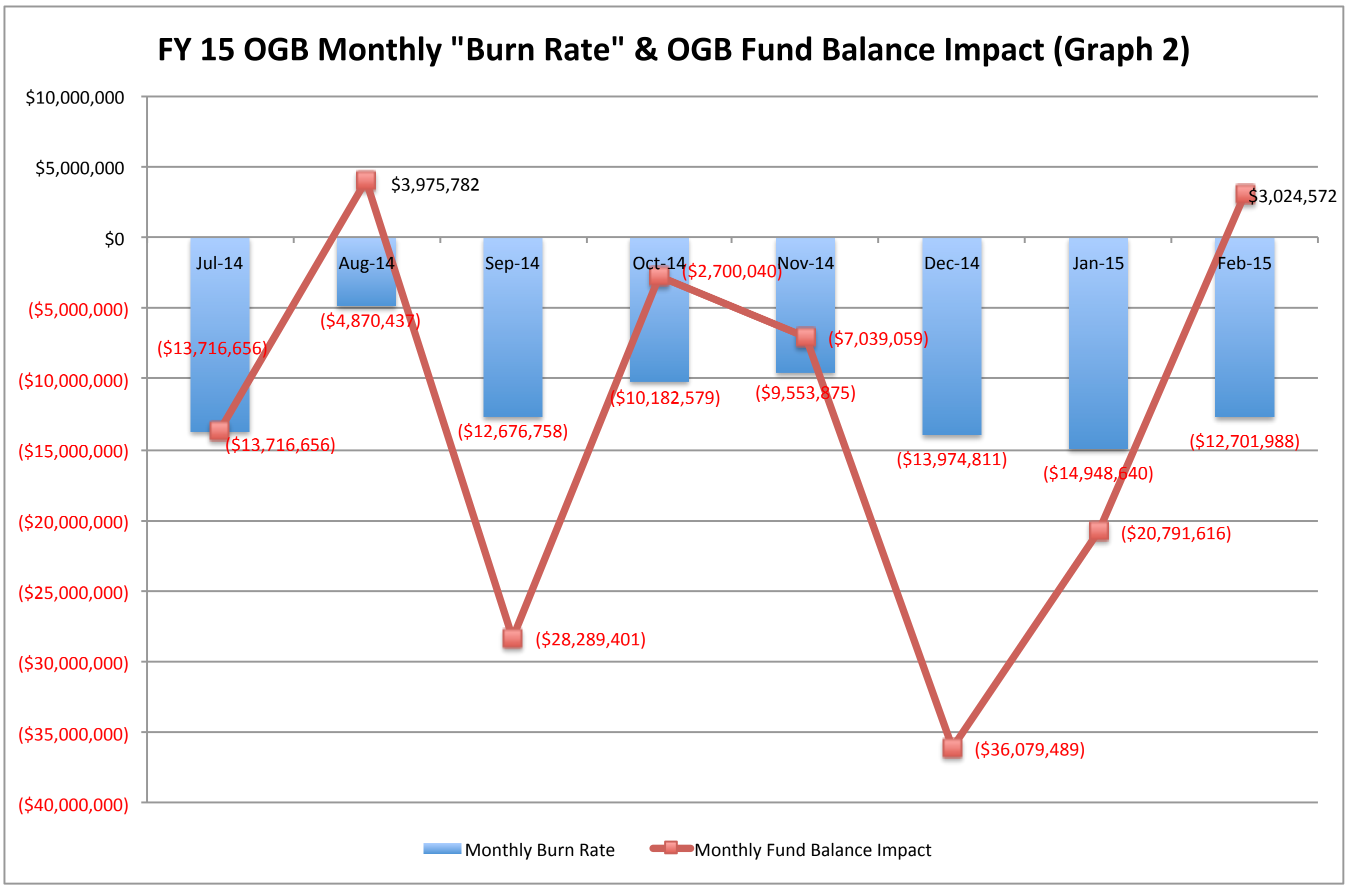


TABLE 1	Fund Balance Impact
July 2014	($13,716,656)
August 2014	$3,975,782
September 2014	($28,289,401)
October 2014	($2,700,040)
November 2014	($7,039,059)
December 2014	($36,079,489)
January 2015	($20,791,616)
February 2015	$3,024,572
TOTAL	**($101,615,907)**

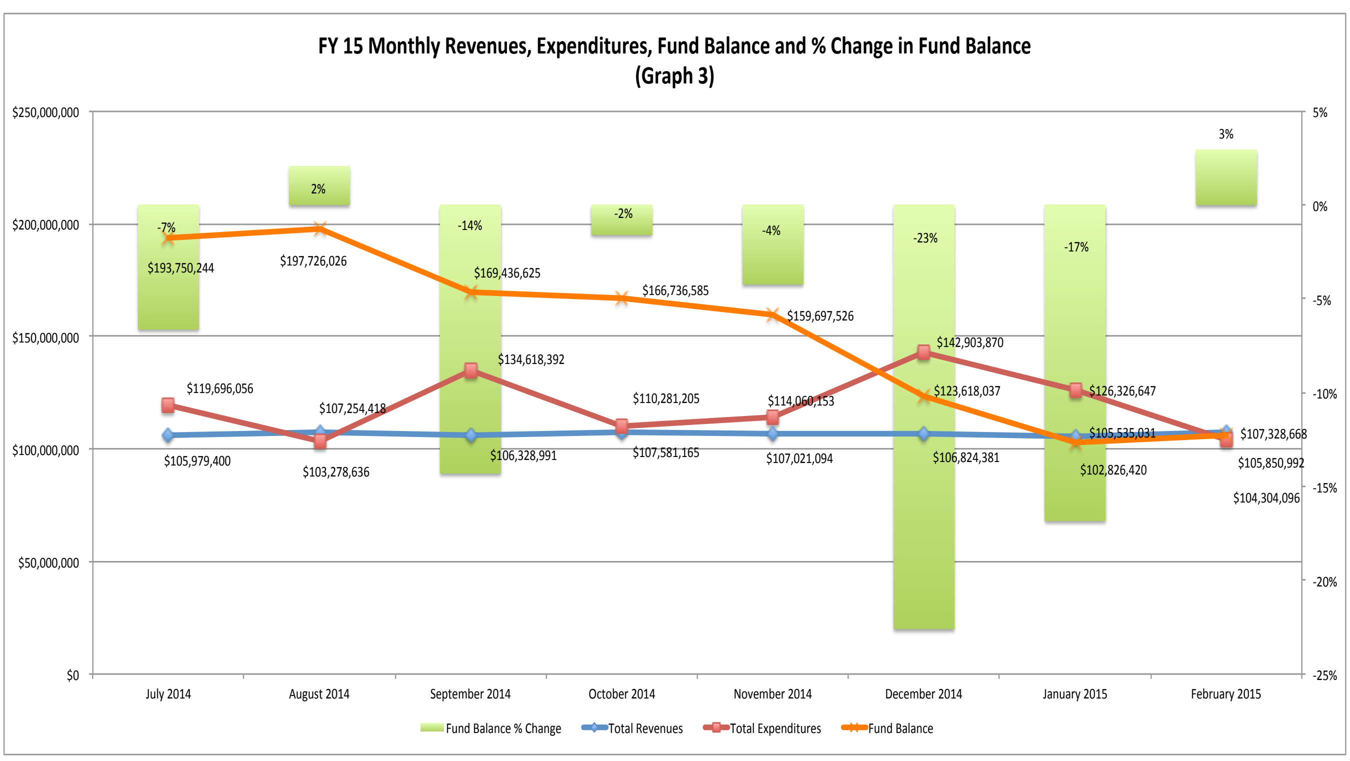
Graph 2 on the next page depicts the FY 15 Monthly OGB fund balance burn rate along with the monthly fund balance dollar change.

To the extent the burn rate does not change, OGB's FY 15 ending year fund balance could be less than $60 M ($12.7 M burn rate x 4 months = $50.8; $105.9 M fund balance less $50.8 M = $55.1 M). However, once the new health plan design changes go into effect on March 1, 2015, the current burn rate of $12.7 M per month may be reduced. *Note: Based upon the Governor's FY 16 Executive Budget presentation, implementing a 10.8% premium increase in FY 16 could result in an FY 16 ending year fund balance of approximately $98 M.*

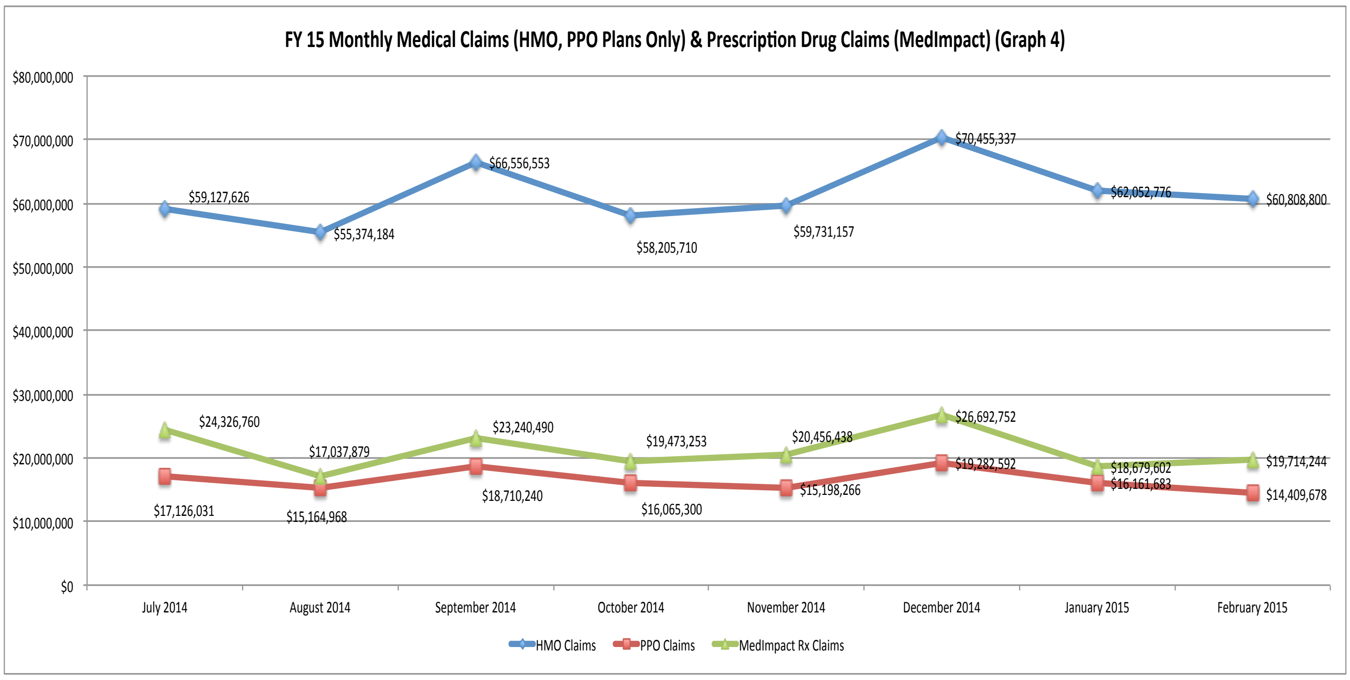


Graph 3 below depicts FY 15 monthly OGB revenues, expenditures, fund balance and percentage change in fund balance through February 2015. February 2015 expenditure activity actually resulted in a net fund balance gain of approximately $3 M, which equates to a positive 3% in OGB fund balance change. Approximately $20.8 M of the fund balance was utilized in January 2015, which is illustrated in the negative 17% change of OGB overall fund balance through the month of January, while the fund gained $3 M in February 2015. Through February 2015 in FY 15 for every $1 of revenue OGB collects, the program is currently expending on average approximately $1.12. See table 2 for more detailed information.

For Every $1 Collected (Table 2)	
Month	**Expended**
Jul-14	$1.13
Aug-14	$0.96
Sep-14	$1.27
Oct-14	$1.03
Nov-14	$1.07
Dec-14	$1.34
Jan-15	$1.20
Feb-15	$0.97
Average	**$1.12**



Graph 4 on the next page is a depiction of monthly medical claims expenditures through February 2015 (PPO, HMO and MedImpact Rx claims only - $94.9 M) for FY 15. These specific expenditures decreased approximately $2 M from the January 2015 data ($96.9 M), which is the second month in a row of decreased medical/pharmacy claims activity from the December 2014 data ($116.4 M), which to date is the high month of claims activity in FY 15.



OGB Enrollment by Plan (2015 Plan Year)

Table 3 below includes enrollment information provided to the Legislative Fiscal Office by the OGB of the health plan choice by its members during annual enrollment. The new health plans are effective March 1, 2015.

TABLE 3	ACTIVE ENROLLEES				RETIRED ENROLLEES				ALL ENROLLEES			
REGULAR PLANS	Plan Year 2014	Plan Year 2015	Difference	% Difference	Plan Year 2014	Plan Year 2015	Difference	% Difference	Plan Year 2014	Plan Year 2015	Difference	% Difference
Magnolia Open Access (PPO)	10,275	8,569	(1,706)	-16.6%	24,885	23,741	(1,144)	-4.6%	35,160	32,310	(2,850)	-8.1%
Magnolia Local	0	405	405	N/A	0	204	204	N/A	0	609	609	N/A
Magnolia Local Plus (HMO)	67,084	64,313	(2,771)	-4.1%	24,358	24,602	244	1.0%	91,442	88,915	(2,527)	-2.8%
Pelican HRA 1000	0	4,482	4,482	N/A	0	924	924	N/A	0	5,406	5,406	N/A
Pelican HSA 775 (CDHSA)	401	2,145	1,744	434.9%	0	0	0	N/A	401	2,145	1,744	434.9%
Vantage MHHP	2,910	3,062	152	5.2%	546	566	20	3.7%	3,456	3,628	172	5.0%
Regular Plans Subtotal	**80,670**	**82,976**	**2,306**	**2.9%**	**49,789**	**50,037**	**248**	**0.5%**	**130,459**	**133,013**	**2,554**	**2.0%**

STATE OF LOUISIANA
LEGISLATIVE FISCAL OFFICE
BATON ROUGE

John D. Carpenter
Legislative Fiscal Officer

Post Office Box 44097
Capitol Station
Baton Rouge, Louisiana 70804
Phone: 225.342.7233
Fax: 225.342.7243

TO: The Honorable James R. Fannin, Chairman Joint Legislative Committee on the Budget (JLCB)
The Honorable Jack Donahue, Vice Chairman Joint Legislative Committee on the Budget (JLCB)
Honorable Members of the Joint Legislative Committee on the Budget (JLCB)

FROM: J. Travis McIlwain, Section Director
John D. Carpenter, Legislative Fiscal Officer

DATE: February 20, 2015

SUBJECT: Office of Group Benefits (OGB) Update (February 2015)

Graph 1 below depicts the OGB Fund Balance History from FY 08 to FY 14 along with the ending balance for the months of July 2014 through January 2015 (FY 15). During the month of January, OGB's fund balance lost approximately $20.8 M, or a negative 17% fund balance change.

Since the beginning of FY 15, OGB's expenditures have been approximately $104.6 M more than actual revenue collections through January 2015. This has resulted in the OGB fund balance decreasing from $207 M (beginning of FY 15) to $102.8 M (through January 2015). The decrease equates to an updated FY 15 monthly burn rate of approximately $14.9 M per month, which equates to an increase from the December 2014 monthly burn rate of $13.9 M per month. OGB's cash on hand through January 2015 is approximately $192.1 M. Table 1 below portrays the monthly OGB fund balance impact in FY 15.

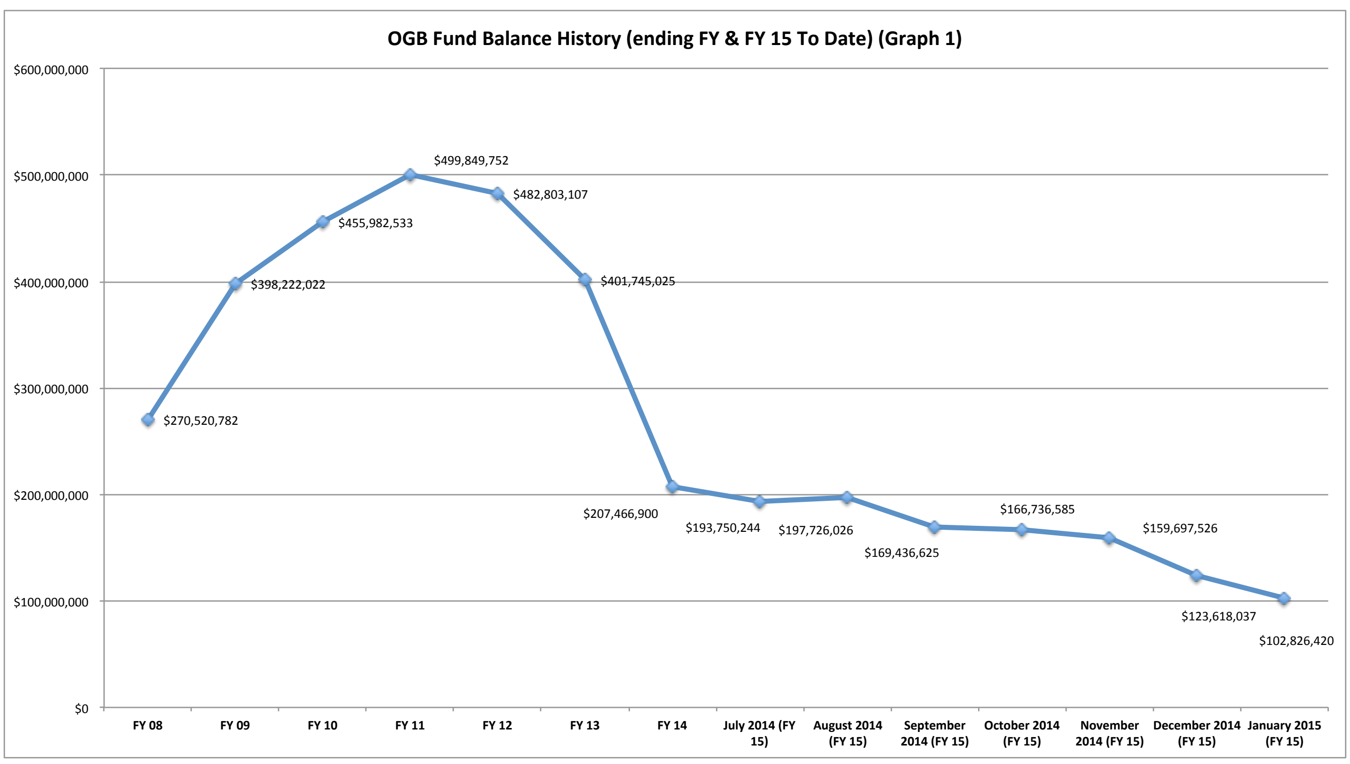
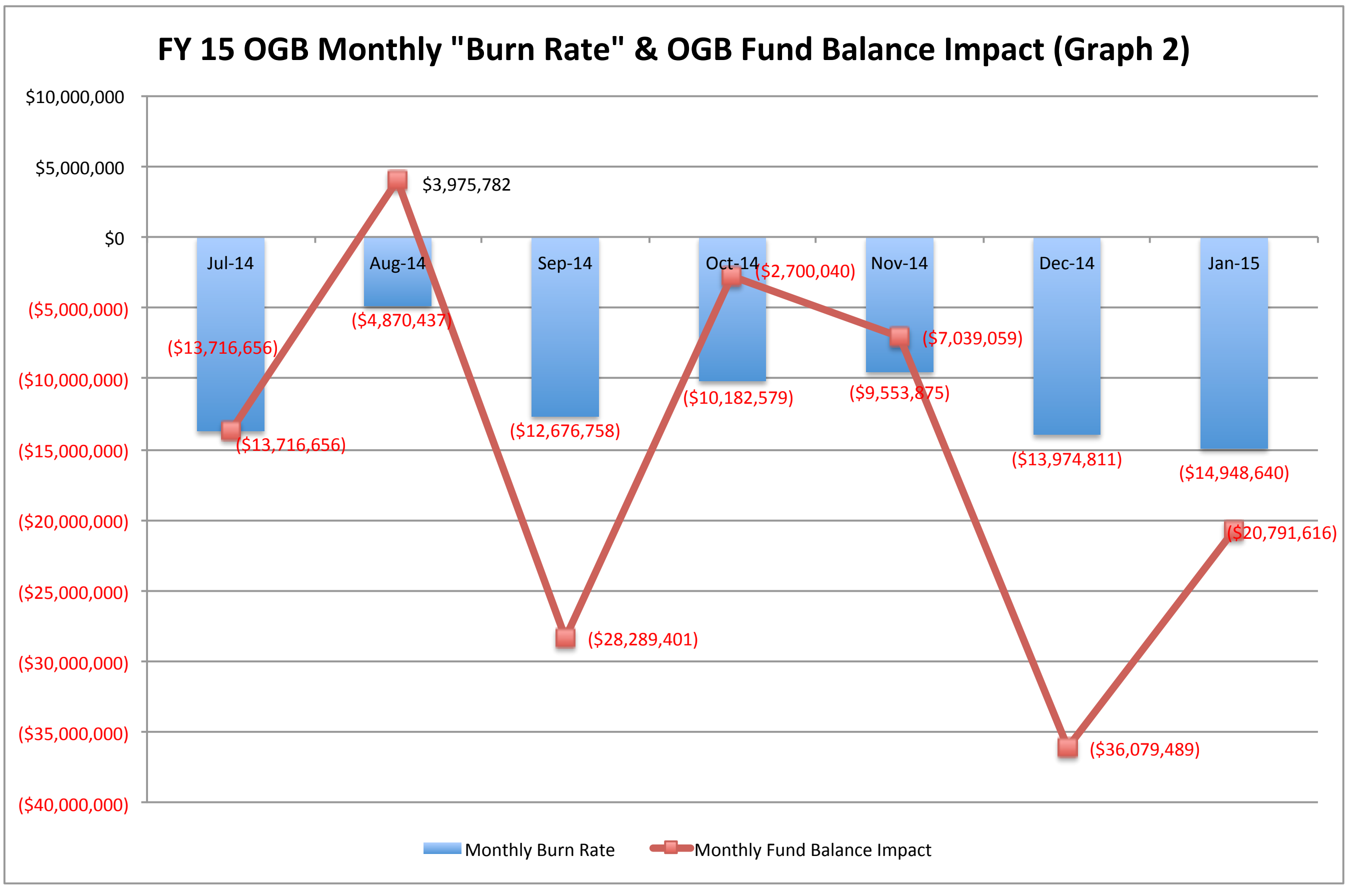


TABLE 1	Fund Balance Impact
July 2014	($13,716,656)
August 2014	$3,975,782
September 2014	($28,289,401)
October 2014	($2,700,040)
November 2014	($7,039,059)
December 2014	($36,079,489)
January 2015	($20,791,616)
TOTAL	**($104,640,479)**

Graph 2 on the next page depicts the FY 15 Monthly OGB fund balance burn rate along with the monthly fund balance dollar change.

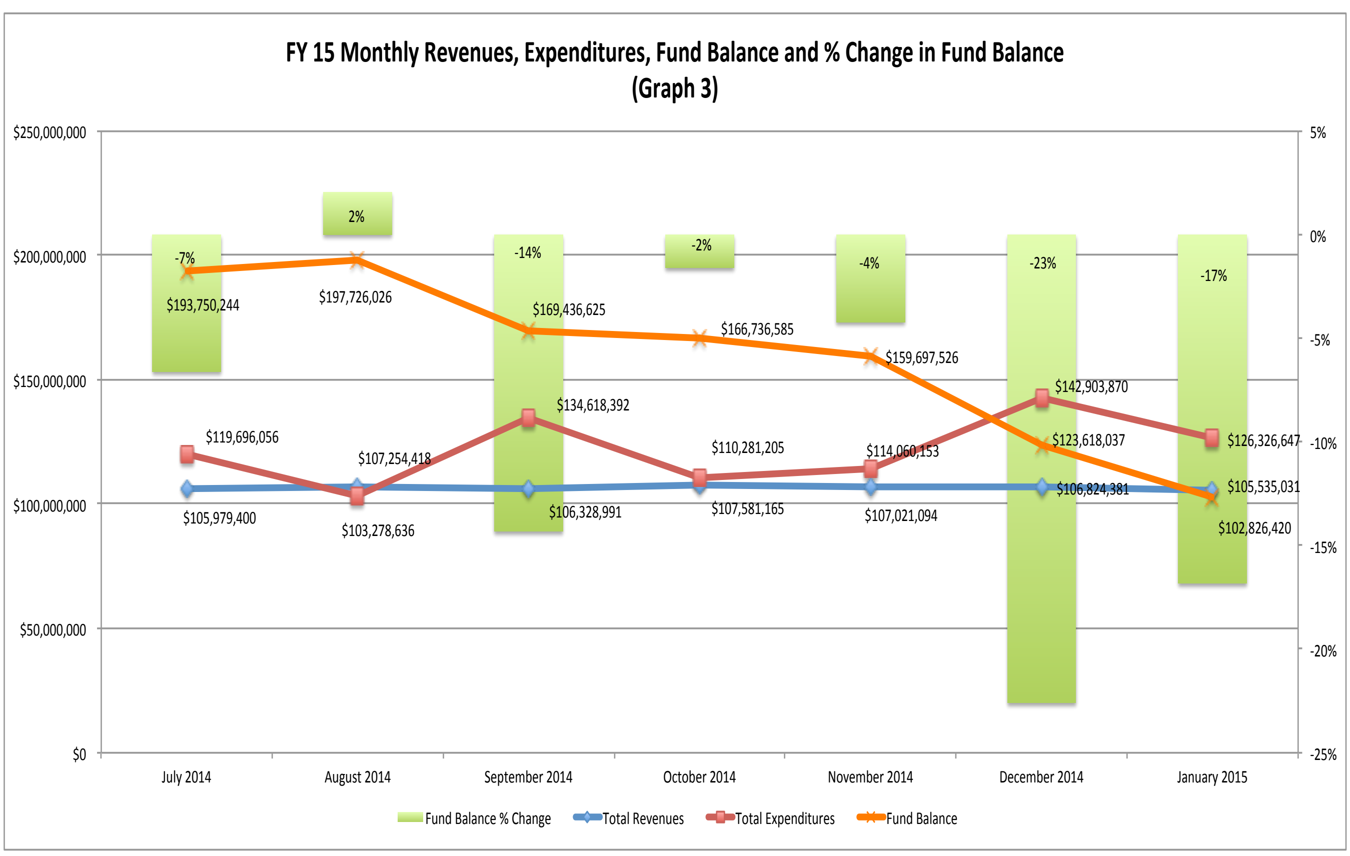
To the extent the burn rate does not change, OGB's FY 15 ending year fund balance could be less than $30 M. However, once the new plan design changes go into effect on March 1, 2015, the current burn rate of $14.9 M per month may be reduced. These changes may result in the OGB's FY 15 year-end fund balance equating to some amount greater than $60 M.



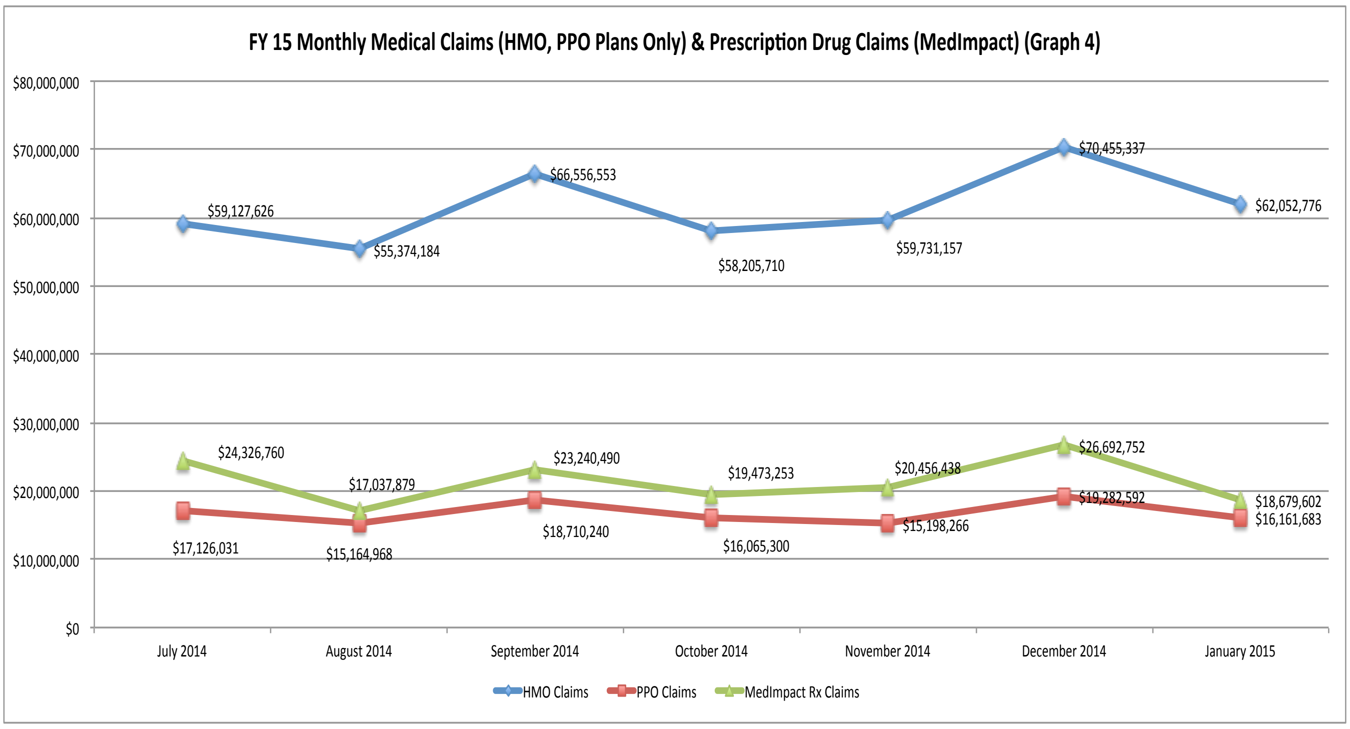
Graph 3 below depicts FY 15 monthly OGB revenues, expenditures, fund balance and percentage change in fund balance through January 2015. January 2015 expenditure activity utilized approximately $20.8 M of OGB's current fund balance to pay expenditures, which is a decrease of fund balance use from December 2014. Approximately $36.1 M of the fund balance was utilized in December 2014, which is illustrated in the negative 23% change of OGB overall fund balance through the month of December. For the month of January that negative percent change slightly decreased to a negative 17% change.

For Every $1 Collected (Table 2)	
Month	**Expended**
Jul-14	$1.13
Aug-14	$0.96
Sep-14	$1.27
Oct-14	$1.03
Nov-14	$1.07
Dec-14	$1.34
Jan-15	$1.20
Average	**$1.14**

Through January 2015 for every $1 of revenue OGB collects, the program is currently expending on average approximately $1.14. See table 2 above for more detailed information.



Graph 4 is a depiction of monthly medical claims expenditures through January 2015 (PPO, HMO and MedImpact Rx claims only) for FY 15. These specific expenditures decreased by approximately 12% from the December 2014 data.



OGB Enrollment by Plan (2015 Plan Year)

Table 3 below includes enrollment information provided to the Legislative Fiscal Office by the OGB of the health plan choice by its members during annual enrollment. The new health plans are effective March 1, 2015.

TABLE 3	ACTIVE ENROLLEES				RETIRED ENROLLEES				ALL ENROLLEES			
REGULAR PLANS	Plan Year 2014	Plan Year 2015	Difference	% Difference	Plan Year 2014	Plan Year 2015	Difference	% Difference	Plan Year 2014	Plan Year 2015	Difference	% Difference
Magnolia Open Access (PPO)	10,275	8,569	(1,706)	-16.6%	24,885	23,741	(1,144)	-4.6%	35,160	32,310	(2,850)	-8.1%
Magnolia Local	0	405	405	N/A	0	204	204	N/A	0	609	609	N/A
Magnolia Local Plus (HMO)	67,084	64,313	(2,771)	-4.1%	24,358	24,602	244	1.0%	91,442	88,915	(2,527)	-2.8%
Pelican HRA 1000	0	4,482	4,482	N/A	0	924	924	N/A	0	5,406	5,406	N/A
Pelican HSA 775 (CDHSA)	401	2,145	1,744	434.9%	0	0	0	N/A	401	2,145	1,744	434.9%
Vantage MHHP	2,910	3,062	152	5.2%	546	566	20	3.7%	3,456	3,628	172	5.0%
Regular Plans Subtotal	**80,670**	**82,976**	**2,306**	**2.9%**	**49,789**	**50,037**	**248**	**0.5%**	**130,459**	**133,013**	**2,554**	**2.0%**

STATE OF LOUISIANA
LEGISLATIVE FISCAL OFFICE
BATON ROUGE

John D. Carpenter
Legislative Fiscal Officer

Post Office Box 44097
Capitol Station
Baton Rouge, Louisiana 70804
Phone: 225.342.7233
Fax: 225.342.7243

TO: The Honorable James R. Fannin, Chairman Joint Legislative Committee on the Budget (JLCB)
The Honorable Jack Donahue, Vice Chairman Joint Legislative Committee on the Budget (JLCB)
Honorable Members of the Joint Legislative Committee on the Budget (JLCB)

FROM: J. Travis McIlwain, Section Director
John D. Carpenter, Legislative Fiscal Officer

DATE: January 16, 2015

SUBJECT: Office of Group Benefits (OGB) Update (January 2015)

Graph 1 below depicts the OGB Fund Balance History from FY 08 to FY 14 along with the ending balance for the months of July 2014 through December 2014 (FY 15). During the month of December, OGB's fund balance lost approximately $36.1 M, or a 23% fund balance change.

Since the beginning of FY 15, OGB's expenditures have been approximately $83.8 M more than actual revenue collections through December 2014. This has resulted in the OGB fund balance decreasing from $207 M to $123.6 M. The decrease equates to an updated FY 15 monthly burn rate of $13.9 M per month through December 2014. The November 2014 monthly burn rate was $9.6 M.

Table 1 below illustrates the monthly OGB fund balance impact in FY 15.

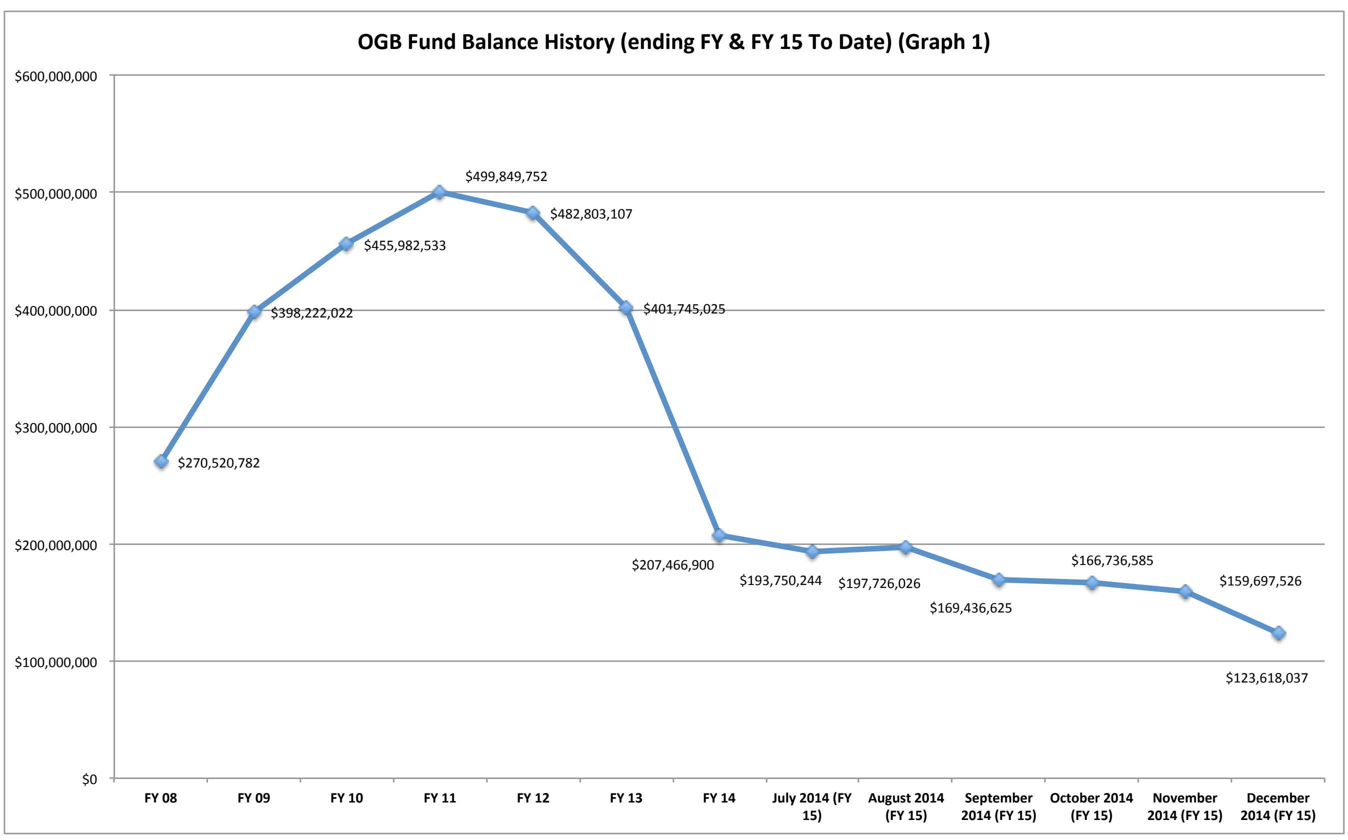
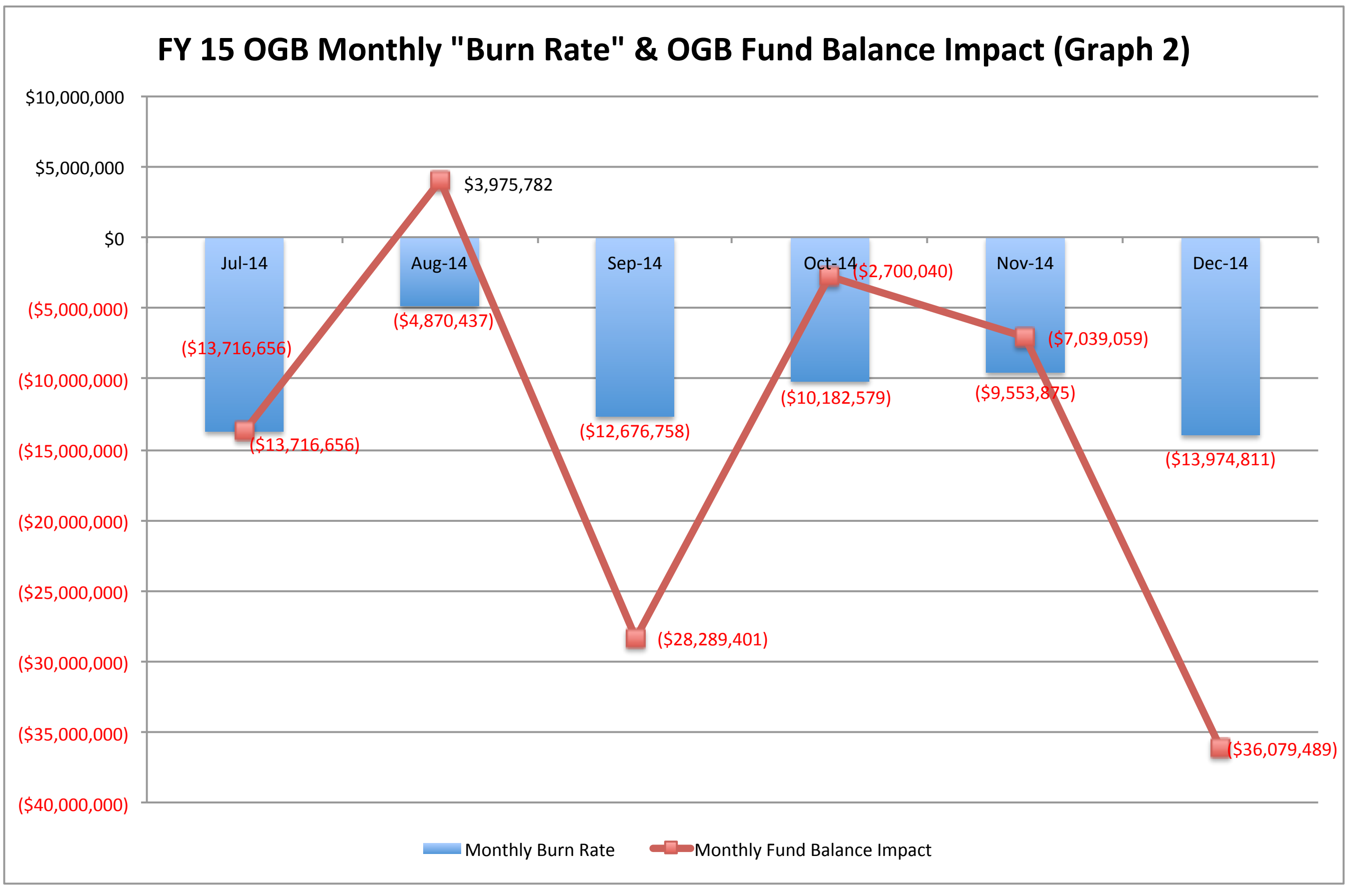


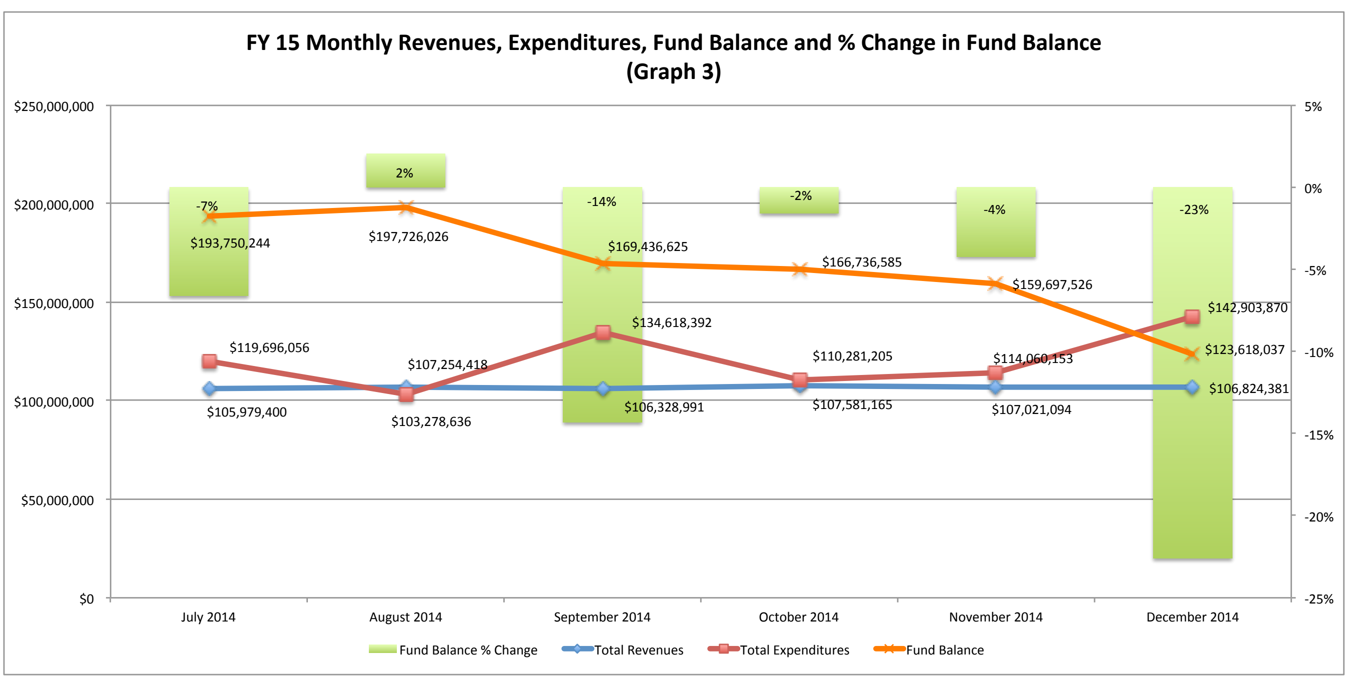
TABLE 1	Fund Balance Impact
July 2014	($13,716,656)
August 2014	$3,975,782
September 2014	($28,289,401)
October 2014	($2,700,040)
November 2014	($7,039,059)
December 2014	($36,079,489)
TOTAL	**($83,848,863)**

Graph 2 on the next page depicts the FY 15 Monthly OGB fund balance burn rate along with the monthly fund balance dollar change.

To the extent the burn rate does not change, OGB's FY 15 ending year fund balance could be less than $40 M. However, once the new plan design changes go into effect on March 1, 2015, the current burn rate of $13.9 M per month will be reduced, which will likely result in the FY 15 ending year fund balance to be some amount greater than $90 M.

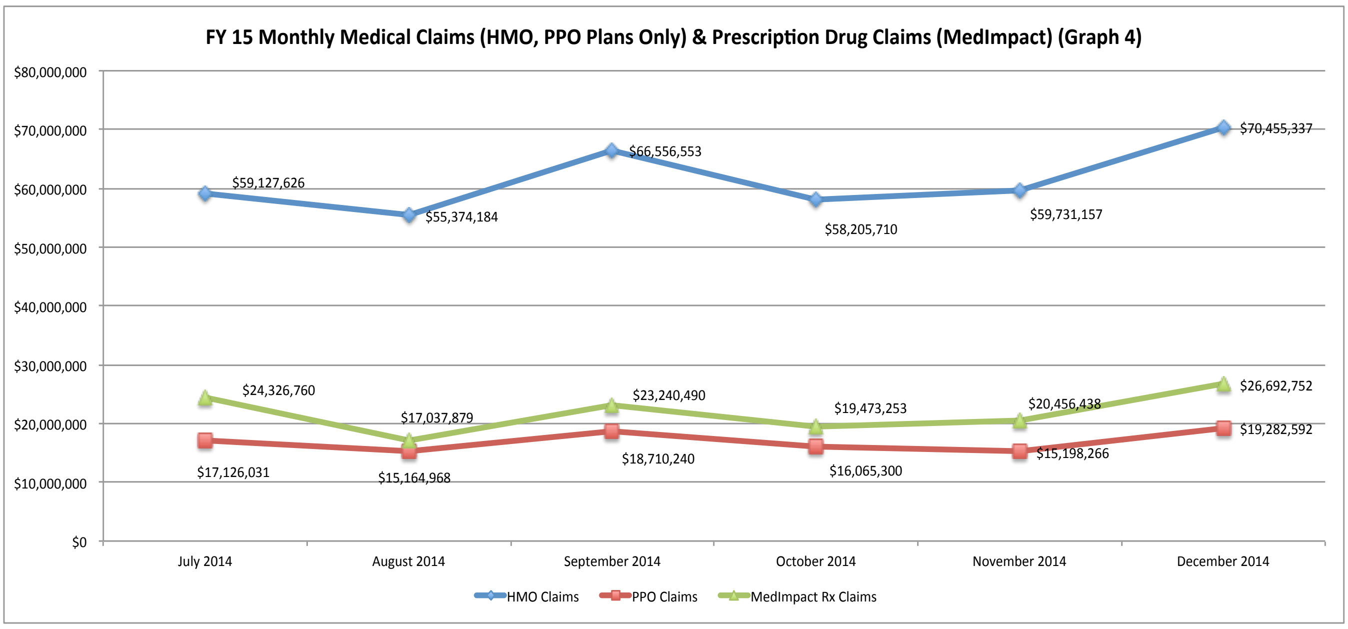


Graph 3 below depicts FY 15 monthly OGB revenues, expenditures, fund balance and percentage change in fund balance through December 2014. December 2014 activity utilized approximately $36.1 M of OGB's current fund balance to pay expenditures, which is a **413% increase** of fund balance use from November 2014 ($7 M of the fund balance was utilized). In November 2014, OGB utilized approximately $7 M of fund balance that is illustrated in the negative 4% change of OGB overall fund balance through the month of November, while for the month of December that negative percent change grew to 23%.



Graph 4 is a depiction of monthly medical claims expenditures through December 2014 (PPO, HMO and MedImpact Rx claims only) for FY 15. These specific expenditures grew by approximately 22% from the November 2014 data.

This graph can be found on the next page.



FY 15 Monthly Medical Claims (HMO, PPO Plans Only) & Prescription Drug Claims (MedImpact) (Graph 4)
$80,000,000
$70,000,000
$60,000,000
$50,000,000
$40,000,000
$30,000,000
$20,000,000
$10,000,000
$0
$59,127,626
$55,374,184
$66,556,553
$58,205,710
$59,731,157
$70,455,337
$24,326,760
$17,037,879
$23,240,490
$19,473,253
$20,456,438
$26,692,752
$17,126,031
$15,164,968
$18,710,240
$16,065,300
$15,198,266
$19,282,592
July 2014
August 2014
September 2014
October 2014
November 2014
December 2014
HMO Claims
PPO Claims
MedImpact Rx Claims

STATE OF LOUISIANA
LEGISLATIVE FISCAL OFFICE
BATON ROUGE

John D. Carpenter
Legislative Fiscal Officer

Post Office Box 44097
Capitol Station
Baton Rouge, Louisiana 70804
Phone: 225.342.7233
Fax: 225.342.7243

TO: The Honorable James R. Fannin, Chairman Joint Legislative Committee on the Budget (JLCB)
The Honorable Jack Donahue, Vice Chairman Joint Legislative Committee on the Budget (JLCB)
Honorable Members of the Joint Legislative Committee on the Budget (JLCB)

FROM: J. Travis McIlwain, Section Director
John D. Carpenter, Legislative Fiscal Officer

DATE: December 18, 2014

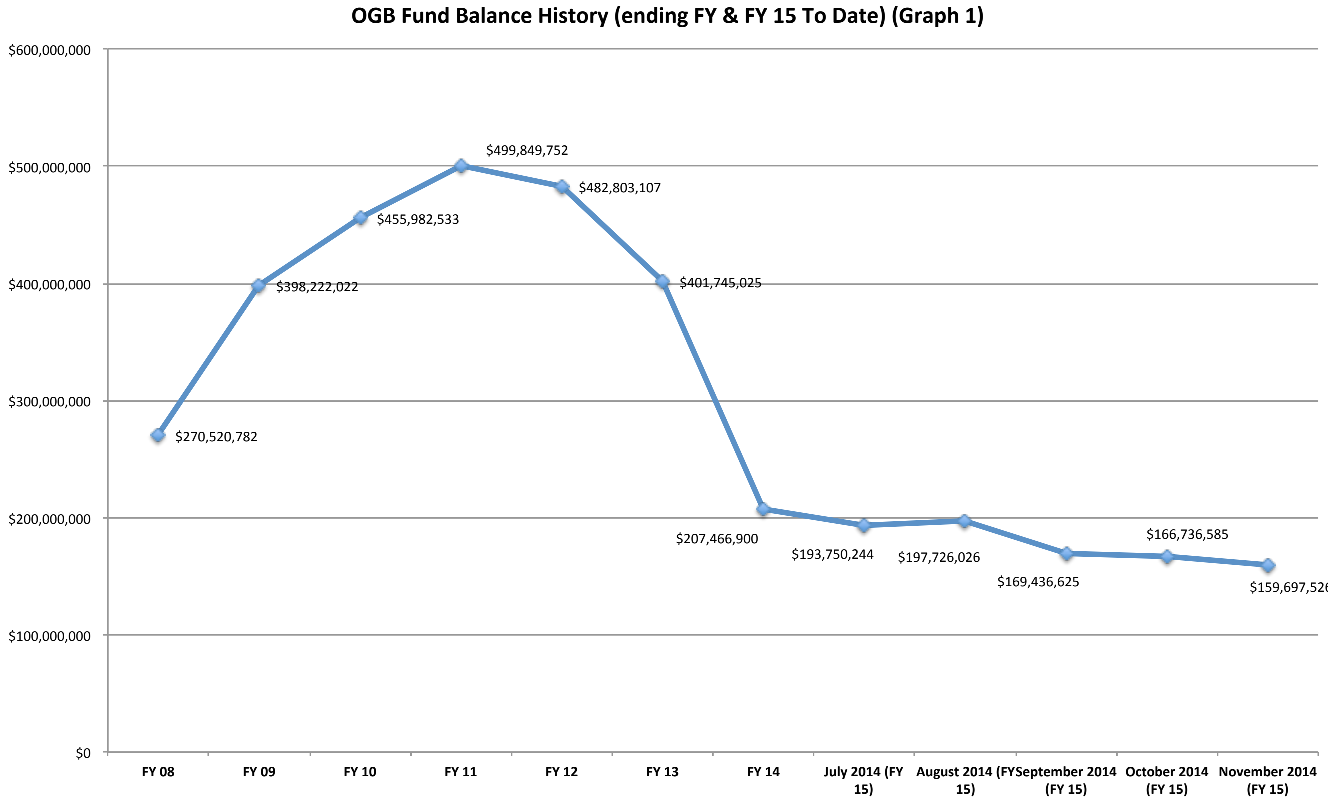
SUBJECT: Office of Group Benefits (OGB) Update (December 2014)

Graph 1 below depicts the OGB Fund Balance History from FY 08 to FY 14 along with the ending balance for the months of July 2014 through November 2014 (FY 15). During the month of November, OGB's fund balance lost approximately $7 M.

Since the beginning of FY 15, OGB's expenditures have been approximately $48 M more than actual revenue collections through November 2014. This has resulted in the OGB fund balance decreasing from $207 M to $159.7 M. The decrease equates to an updated monthly burn rate of $9.6 M per month through November 2014.

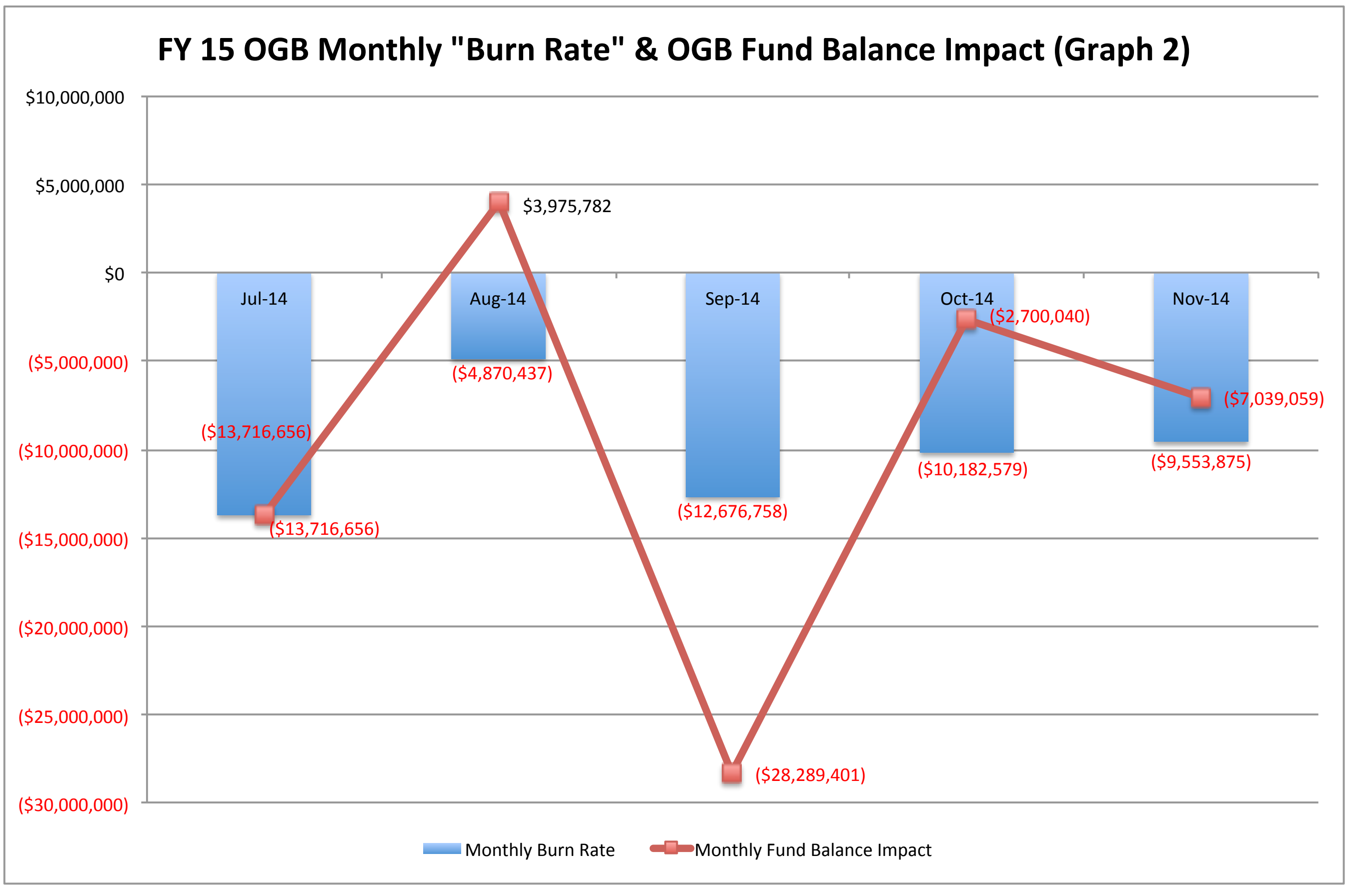
Note: The November 2014 financials include the re-adjudicated financial repayments to OGB members from implementing the August 1, 2014 changes without going through the administrative rule making process. The OGB anticipated these payments to equate to approximately $4.5 M.

OGB Fund Balance History (ending FY & FY 15 To Date) (Graph 1)

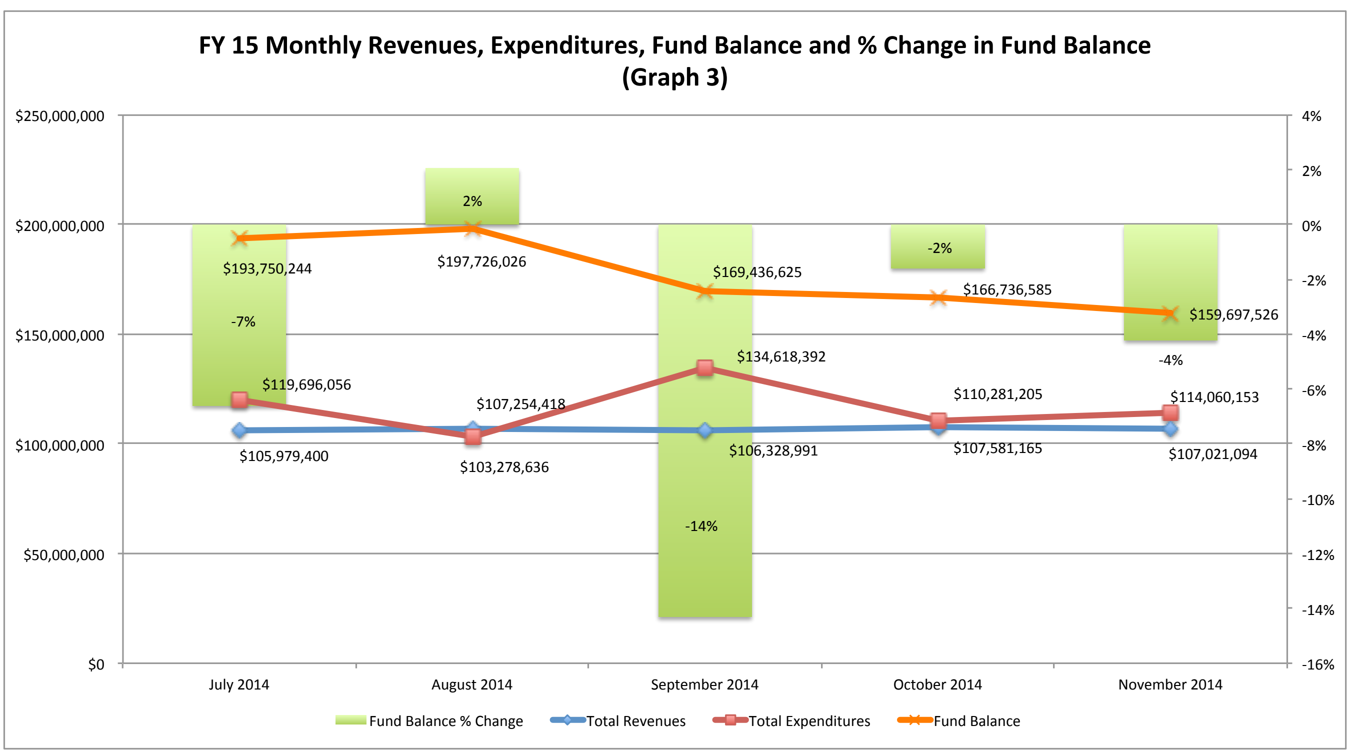


Graph 2 on the next page depicts the FY 15 Monthly OGB fund balance burn rate along with the monthly fund balance dollar change.

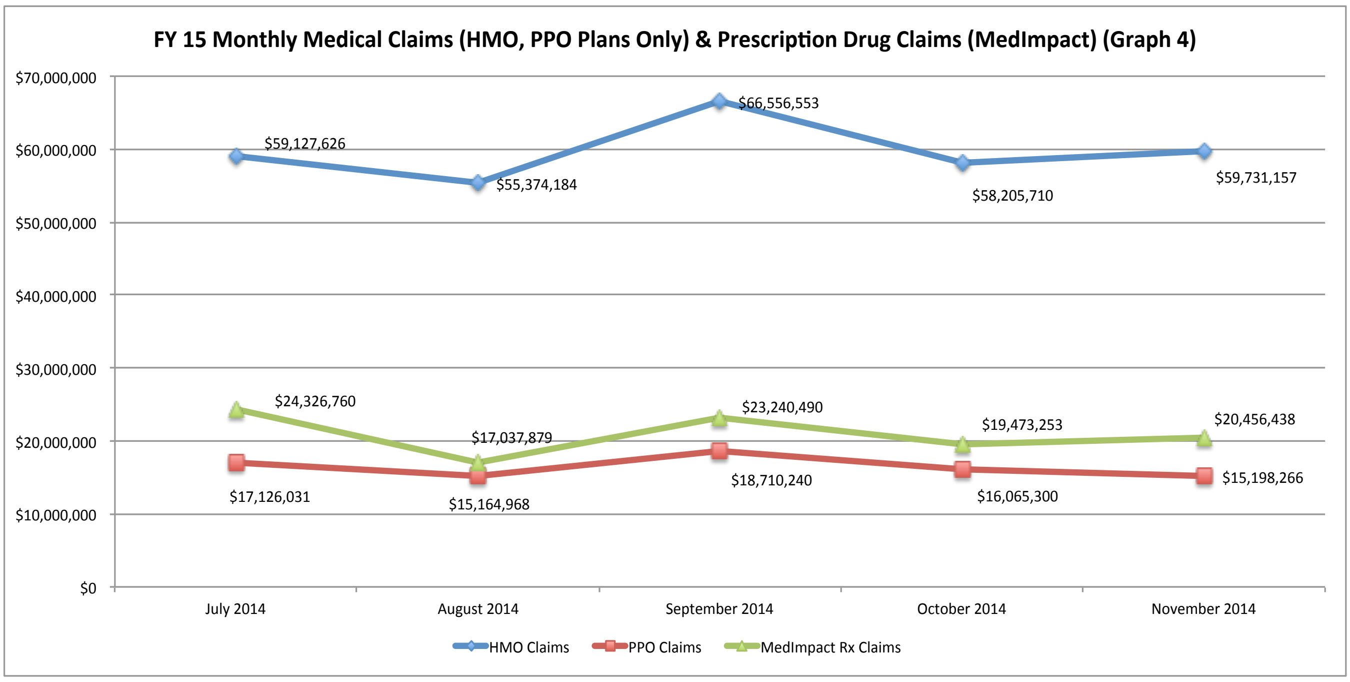
To the extent the burn rate does not change, OGB's FY 15 ending year fund balance could be less than $95 M. However, once the new plan design changes go into effect on March 1, 2015, the current burn rate of $9.6 M per month will likely be reduced, which may result in the FY 15 ending year fund balance to be some amount greater than $95 M.



Graph 3 depicts FY 15 monthly OGB revenues, expenditures, fund balance and percentage change in fund balance through November 2014. November expenditure activity utilized approximately $7 M of OGB's current fund balance to pay expenditures, which is a 161% increase of fund balance use from October 2014 ($2.7 M of the fund balance was utilized). In October 2014, OGB utilized approximately $2.7 M of fund balance that is illustrated in the negative 2% change of OGB overall fund balance through the month of October, while for the month of November that negative percent change grew to 4%.



Graph 4 is a depiction of monthly medical claims expenditures through November 2014 (PPO, HMO and MedImpact Rx claims only) for FY 15. This graph can be found on the next page.


FY 15 Monthly Medical Claims (HMO, PPO Plans Only) & Prescription Drug Claims (MedImpact) (Graph 4)
$70,000,000
$60,000,000
$50,000,000
$40,000,000
$30,000,000
$20,000,000
$10,000,000
$0
$59,127,626
$55,374,184
$66,556,553
$58,205,710
$59,731,157
$24,326,760
$17,037,879
$23,240,490
$19,473,253
$20,456,438
$17,126,031
$15,164,968
$18,710,240
$16,065,300
$15,198,266
July 2014
August 2014
September 2014
October 2014
November 2014
HMO Claims
PPO Claims
MedImpact Rx Claims

John D. Carpenter
Legislative Fiscal Officer

STATE OF LOUISIANA
Legislative Fiscal Office
BATON ROUGE

Post Office Box 44097
Capitol Station
Baton Rouge, Louisiana 70804
Phone: 225.342.7233
Fax: 225.342.7243

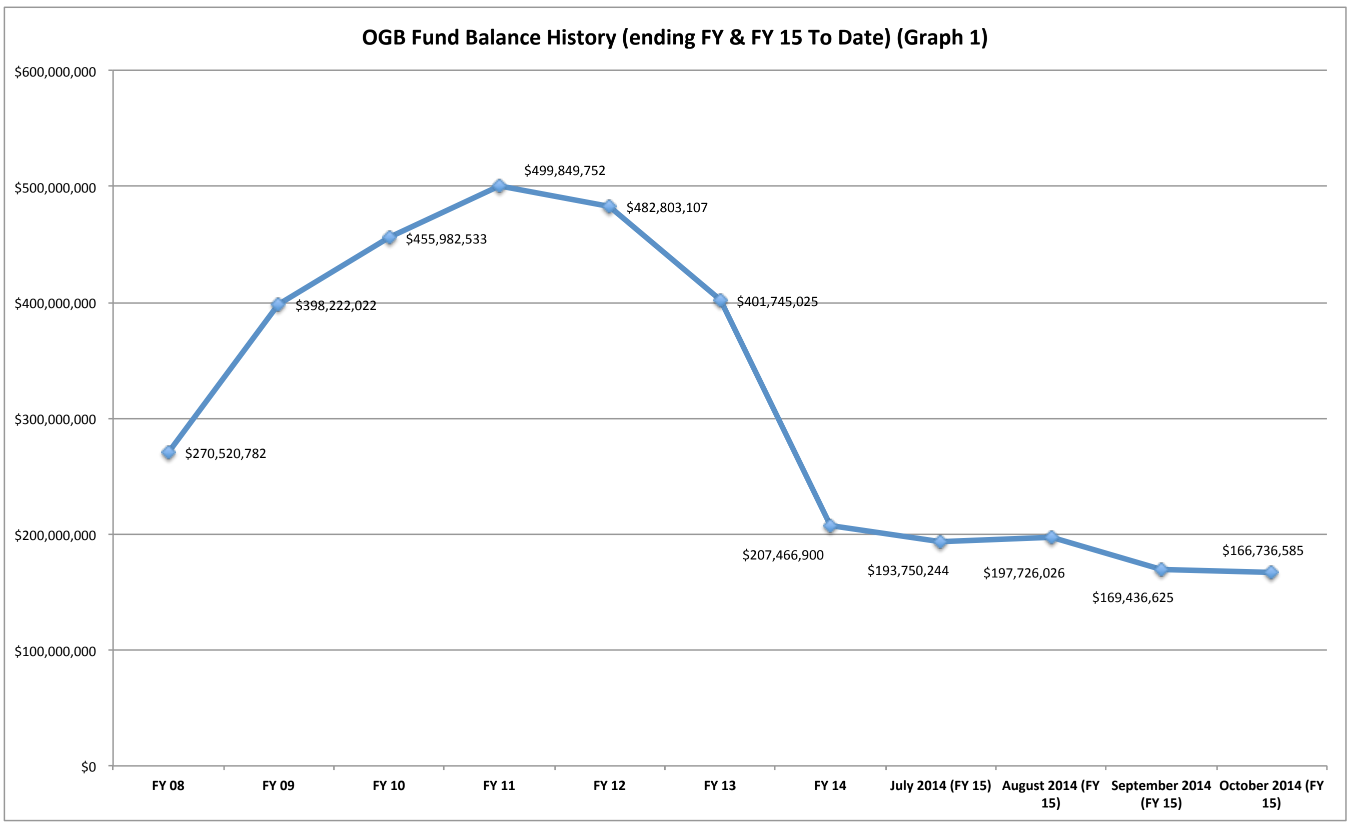
TO: The Honorable James R. Fannin, Chairman Joint Legislative Committee on the Budget (JLCB)
The Honorable Jack Donahue, Vice Chairman Joint Legislative Committee on the Budget (JLCB)
Honorable Members of the Joint Legislative Committee on the Budget (JLCB)

FROM: J. Travis McIlwain, Section Director
John D. Carpenter, Legislative Fiscal Officer

DATE: November 21, 2014

SUBJECT: Office of Group Benefits (OGB) Update (November 2014)

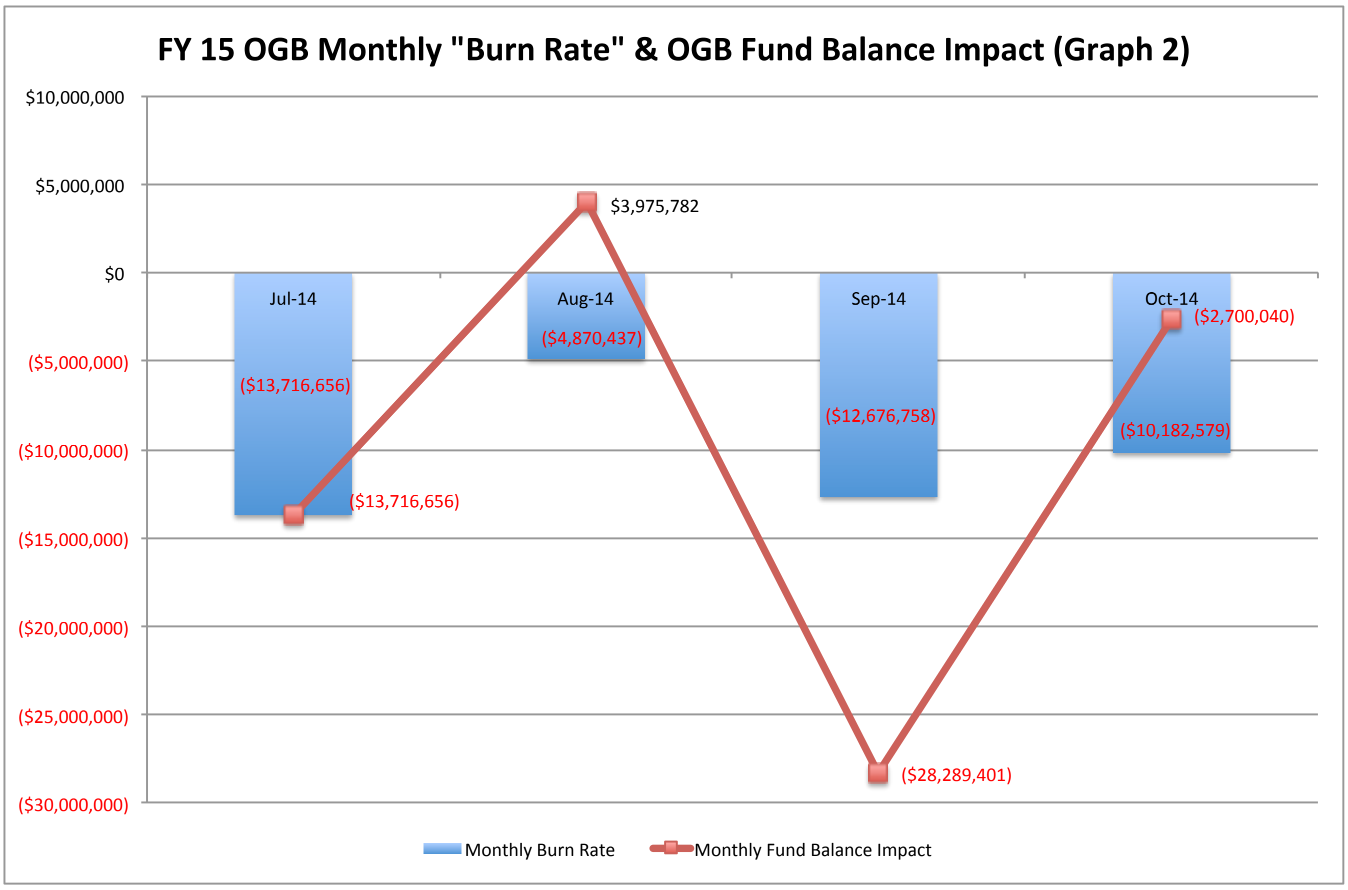
Graph 1 below depicts the OGB Fund Balance History from FY 08 to FY 14 along with ending balance for the months of July 2014 through October 2014 (FY 15).



Since the beginning of FY 15, OGB's expenditures have been approximately $40.7 M more than actual revenue collections through October 2014. This has resulted in the OGB fund balance decreasing from $207 M to $166 M. The decrease equates to an updated monthly burn rate of $10.2 M per month through October 2014.

Graph 2 on the next page depicts the FY 15 Monthly OGB fund balance burn rate along with the monthly fund balance dollar change.

To the extent the burn rate does not change, OGB's FY 15 ending year fund balance could be less than $90 M. However, once the new plan design changes go into effect on March 1, 2015, the current burn rate of $10.2 M per month will likely be reduced, which may result in the FY 15 ending year fund balance to be some amount greater than $90 M.

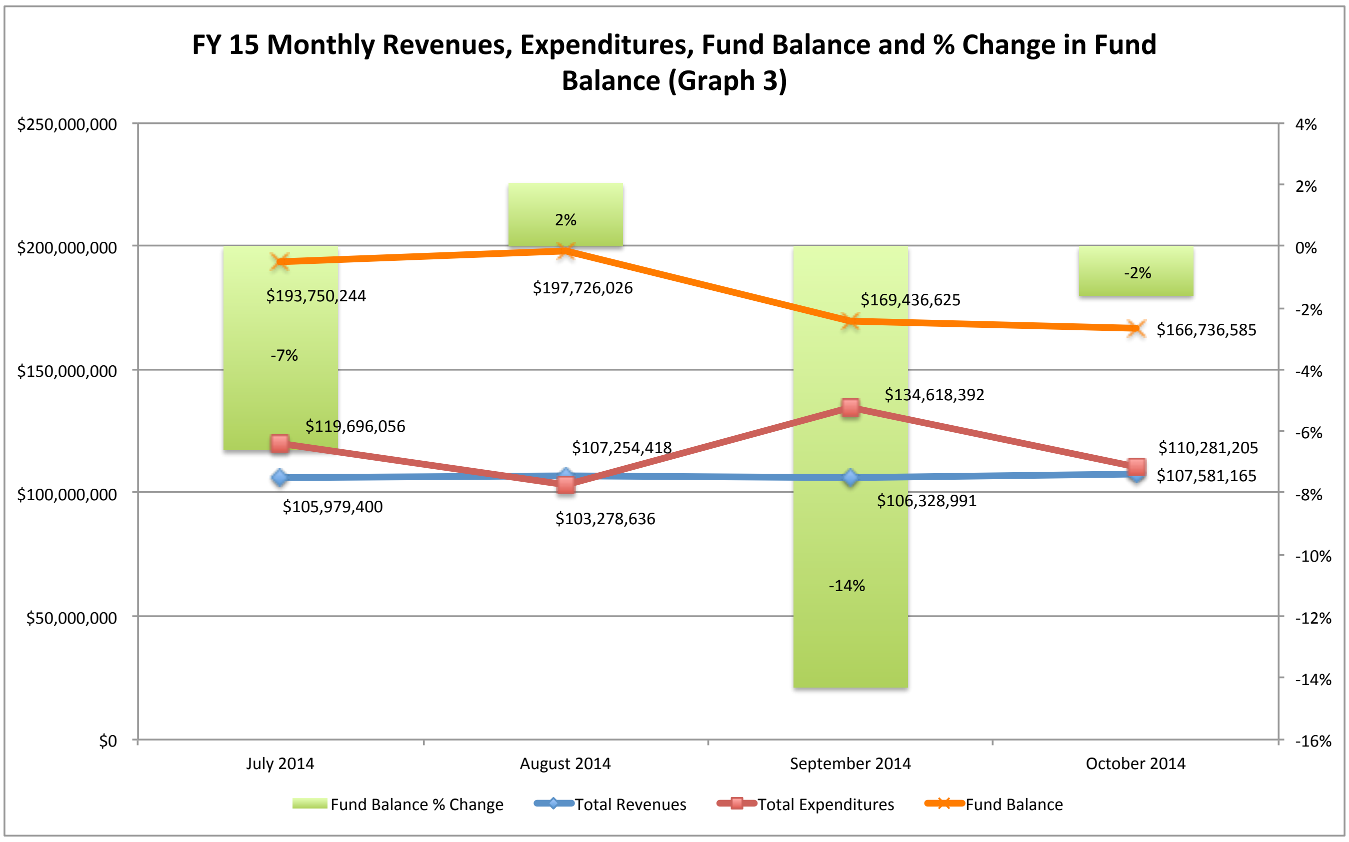


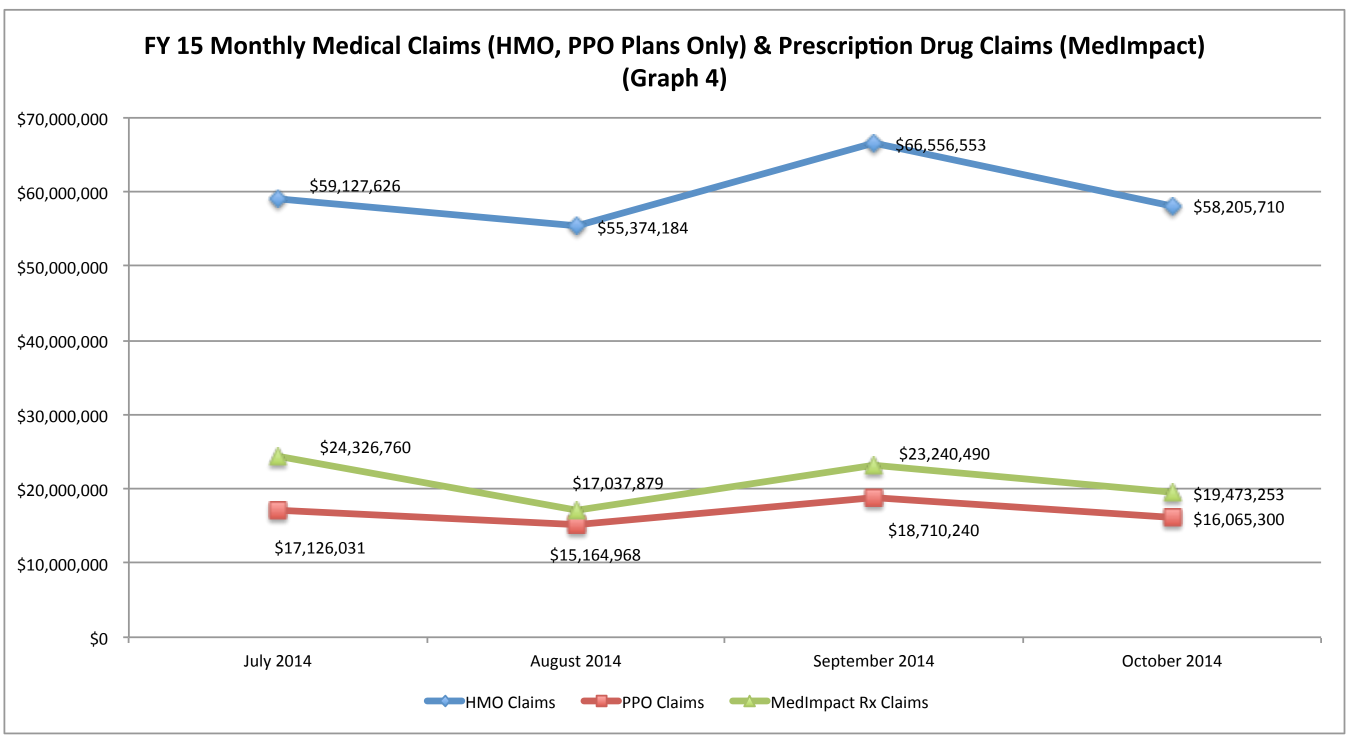
Scaling back the out-of-pocket maximums and deductibles from the original health plan design recommendation is anticipated to decrease the OGB's original cost savings for health plan design changes by approximately $9 M in FY 15. Table 1 below compares the original OGB FY 15 saving estimates to the estimates today accounting for all the changes that have been discussed to date. Based upon the table, the net impact to the OGB original savings as result of modifications equates to approximately $33.5 M of lost savings in FY 15 and annualized lost savings of $27 M in FY 16 for a total two-year savings impact of approximately $60.5 M.

Comparison of Original FY 15 Savings to Today All Net Positive to OGB Fund Balance (Table 1)	Original FY 15 Savings	Moving Annual Enrollment Back To March 1, 2015	Scaling Back OOM & Deductibles	Re-Adjudication August 1st Changes	TOTAL FY 15	Difference Between Original Savings & Current
Total Health Plan Changes Including Prescription Drugs	$131,800,000	($20,033,332)	($8,999,333)	($4,478,303)	$98,289,032	($33,510,968)
5% Premium Increase (Effective July 1, 2014)	$57,900,000	$0	$0	$0	$57,900,000	$0
FY 15 Grand Total Net Impact to OGB Fund Balance	**$189,700,000**	**($20,033,332)**	**($8,999,333)**	**($4,478,303)**	**$156,189,032**	**($33,510,968)**

Graph 3 depicts FY 15 monthly OGB revenues, expenditures, fund balance and percentage change in fund balance through October 2014. October expenditure activity utilized approximately $2.7 M of OGB's current fund balance to pay expenditures, which is a significant improvement from September 2014 in which OGB utilized $28 M of fund balance to pay expenditures. The use of $28 M of fund balance is illustrated in the negative 14% change of OGB overall fund balance through the month of September, while for the month of October that negative percent change has improved to 2%. Graph 4 is a depiction of monthly medical claims expenditures through October 2014 (PPO, HMO and MedImpact Rx claims only) for FY 15.

Both of these graphs are on the next page.


FY 15 Monthly Revenues, Expenditures, Fund Balance and % Change in Fund Balance (Graph 3)
$250,000,000
$200,000,000
$150,000,000
$100,000,000
$50,000,000
$0
4%
2%
0%
-2%
-4%
-6%
-8%
-10%
-12%
-14%
-16%
2%
-7%
-14%
-2%
$193,750,244
$197,726,026
$169,436,625
$166,736,585
$134,618,392
$119,696,056
$107,254,418
$110,281,205
$107,581,165
$105,979,400
$103,278,636
$106,328,991
July 2014
August 2014
September 2014
October 2014
Fund Balance % Change
Total Revenues
Total Expenditures
Fund Balance


FY 15 Monthly Medical Claims (HMO, PPO Plans Only) & Prescription Drug Claims (MedImpact) (Graph 4)
$70,000,000
$60,000,000
$50,000,000
$40,000,000
$30,000,000
$20,000,000
$10,000,000
$0
$59,127,626
$55,374,184
$66,556,553
$58,205,710
$24,326,760
$17,037,879
$23,240,490
$19,473,253
$16,065,300
$17,126,031
$15,164,968
$18,710,240
July 2014
August 2014
September 2014
October 2014
HMO Claims
PPO Claims
MedImpact Rx Claims

STATE OF LOUISIANA
LEGISLATIVE FISCAL OFFICE
BATON ROUGE

John D. Carpenter
Legislative Fiscal Officer

Post Office Box 44097
Capitol Station
Baton Rouge, Louisiana 70804
Phone: 225.342.7233
Fax: 225.342.7243

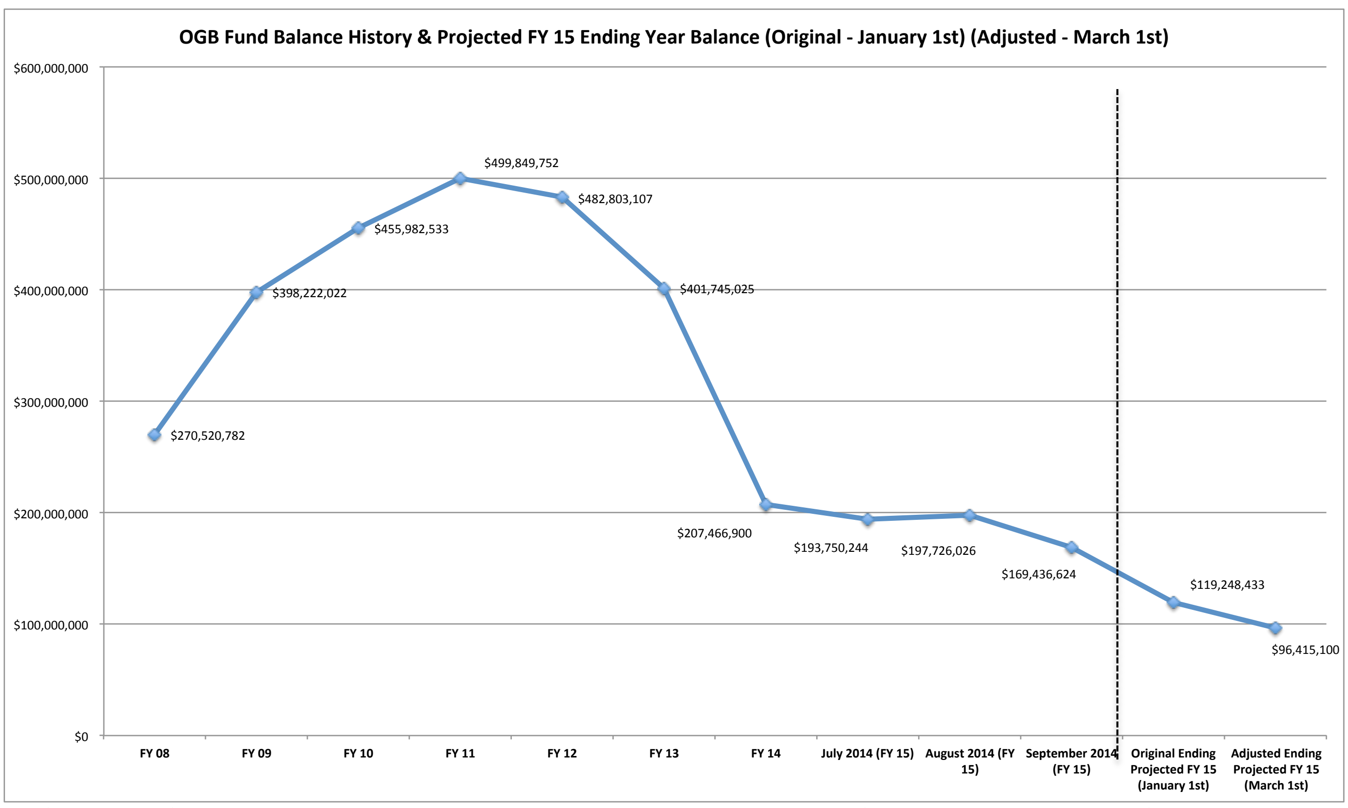
TO: The Honorable James R. Fannin, Chairman Joint Legislative Committee on the Budget (JLCB)
The Honorable Jack Donahue, Vice Chairman Joint Legislative Committee on the Budget (JLCB)
Honorable Members of the Joint Legislative Committee on the Budget (JLCB)

FROM: J. Travis McIlwain, Section Director
John D. Carpenter, Legislative Fiscal Officer

DATE: October 17, 2014

SUBJECT: Office of Group Benefits (OGB) Update (October 2014)

The line graph below depicts the OGB Fund Balance History from FY 08 to FY 14, along with ending July 2014, ending August 2014 and ending September 2014 fund balance actuals. In addition, the line graph depicts the original FY 15 ending year fund balance (with January 1st implementation date) and the adjusted FY 15 ending year fund balance (with extended March 1st implementation).



Changing the implementation date from January 1, 2015 to March 1, 2015 will impact the anticipated OGB ending FY 15 fund balance. Based upon FY 14 actual revenue/expenditure data as the base year, to the extent FY 15 total expenditures increase by the 8-year overall 6% expenditure trend and the March 1st adjusted DOA/OGB anticipated savings actually occur from health plan changes, the FY 15 ending year OGB fund balance would be approximately $96.4 M, or a negative burn rate of approximately $9.4 M during FY 15. Table 1 below depicts the calculation of $96.4 M. ***Note:*** *This calculation assumes the emergency rule is effective.*

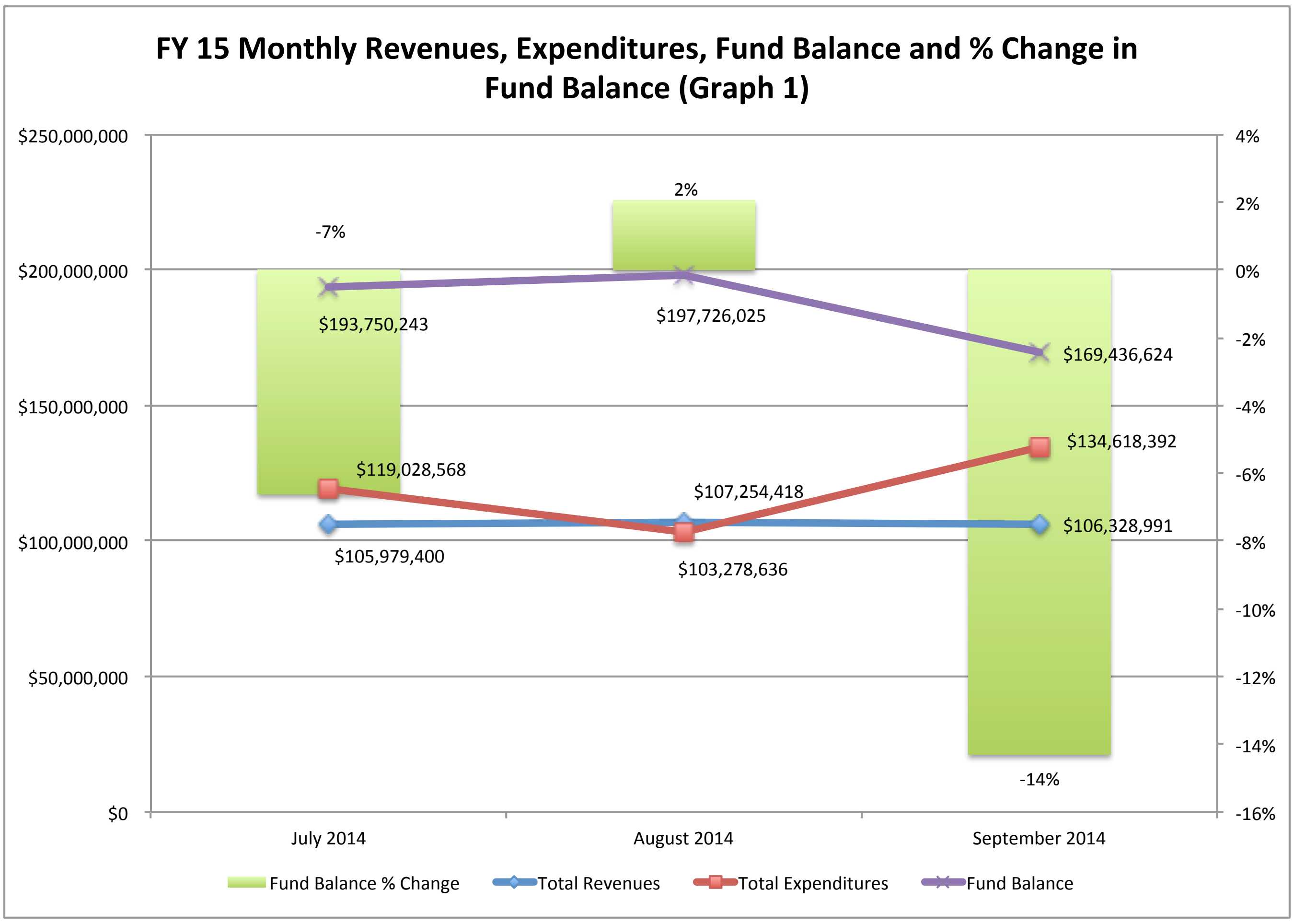
TABLE 1

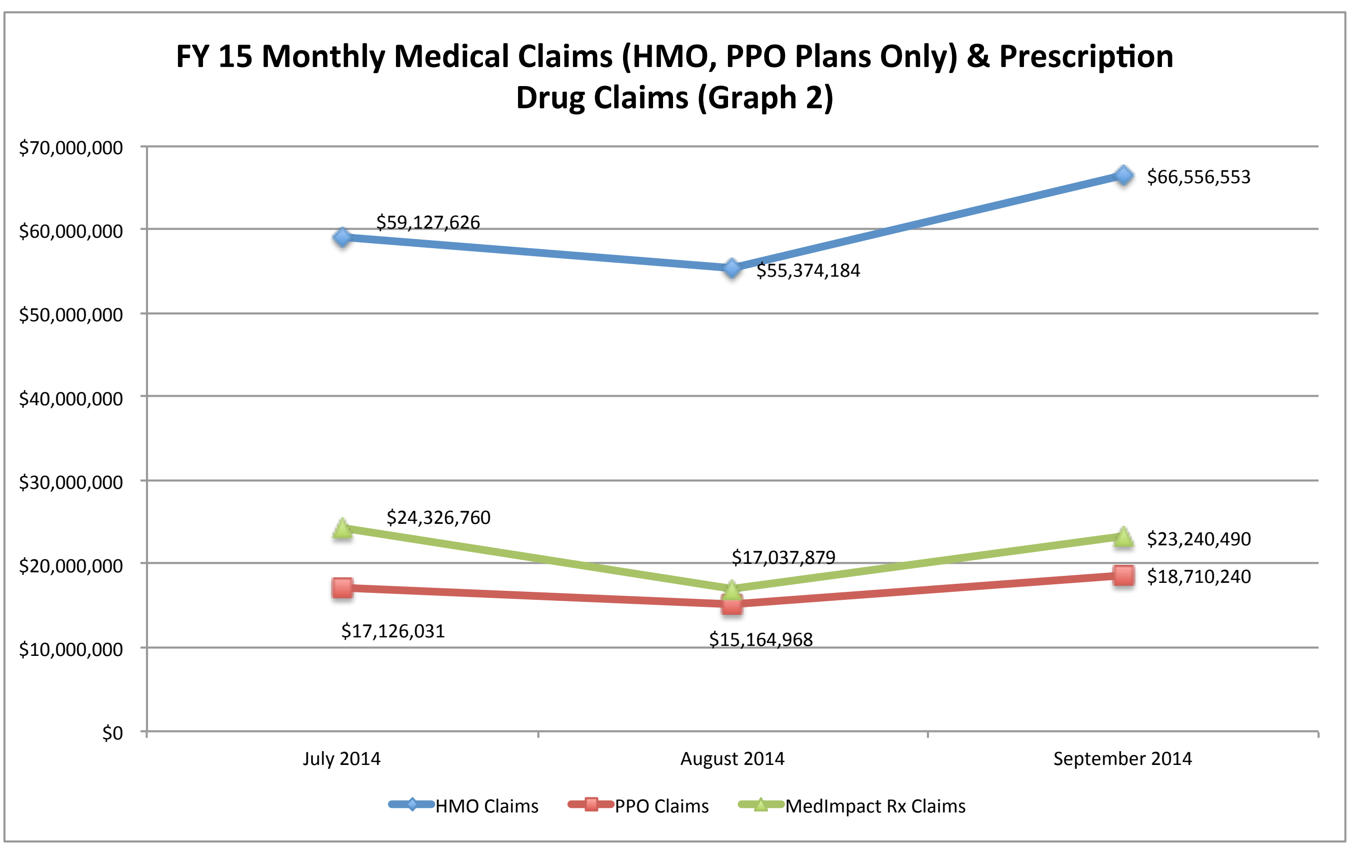
FY 15 Projected Fund Balance	FY 14 Actual	FY 15 w/6% Exp. Growth	Adj FY 15 Health Plan Changes*	FY 15 Projected
Total Revenues	$1,246,394,217	$1,246,394,217	$57,900,000	$1,304,294,217
Total Expenditures	$1,440,672,343	$1,527,112,684	($111,766,667)	$1,415,346,017
Fund Balance Impact	($194,278,126)	($280,718,467)		***($111,051,800)***
Ending Year Fund Balance	**$207,466,900**			***$96,415,100***

** The $57.9 M above is due to the 5% premium rate increase effective July 1, 2014. The ($111.8 M) is based upon adjusted anticipated cost savings from the prescription drug changes in the amount of $69 M, health plan design changes $40.1 M and $2.7 M other standardization changes.*

Since the Division of Administration (DOA)/Office of Group Benefits (OGB) moved the start date of the new OGB plan changes from January 1, 2015 to March 1, 2015, the DOA/OGB is anticipating the 2-month delay to result in an aggregate potential savings decrease of $20 M, or $10 M per month. This calculation is based upon the A & M projected savings calculation for the health plan changes originally expected to go into effect on January 1, 2015 and being in effect from January 1, 2015 to June 30, 2015.

The $96.4 M FY 15 ending year fund balance projection utilizes FY 14 actuals as the base data. However, through the first 3 months of FY 15, OGB's current monthly negative burn rate is approximately $12.7 M per month which is likely due to increased medical claims expenditures in the month of September. Graph 1 below depicts FY 15 monthly OGB revenues, expenditures, fund balance and percentage change in fund balance through September 2014. Based upon the graph below, September expenditure activity (likely driven by medical claims) utilized approximately $28 M of OGB's current fund balance to pay expenditures. Graph 2 below is a depiction of monthly medical claims expenditures (PPO, HMO and MedRx claims only) for FY 2015.





STATE OF LOUISIANA
LEGISLATIVE FISCAL OFFICE
BATON ROUGE

John D. Carpenter
Legislative Fiscal Officer

Post Office Box 44097
Capitol Station
Baton Rouge, Louisiana 70804
Phone: 225.342.7233
Fax: 225.342.7243

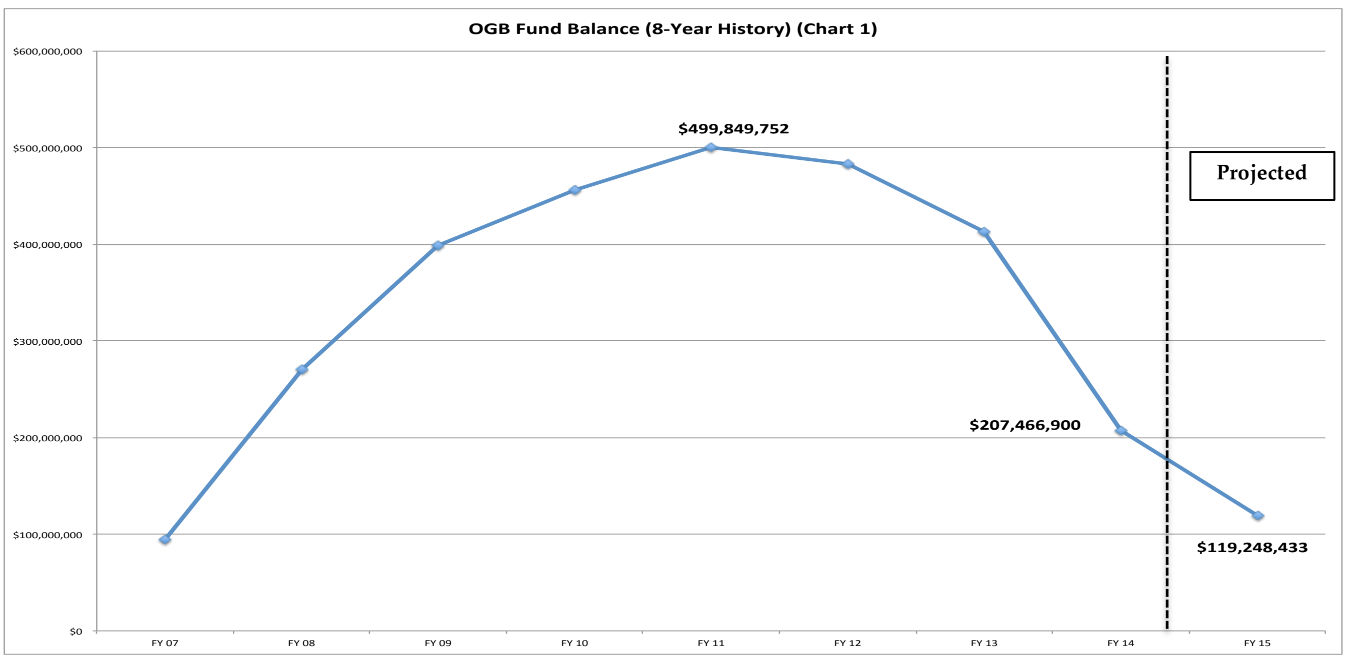
TO: The Honorable James R. Fannin, Chairman Joint Legislative Committee on the Budget (JLCB)
The Honorable Jack Donahue, Vice Chairman Joint Legislative Committee on the Budget (JLCB)
Honorable Members of the Joint Legislative Committee on the Budget (JLCB)

FROM: J. Travis McIlwain, Section Director
John D. Carpenter, Legislative Fiscal Officer

DATE: September 23, 2014

SUBJECT: Office of Group Benefits (OGB) Update **REVISED**

OGB finished FY 14 with a $16.2 M per month negative burn rate, which resulted in the overall fund balance decreasing approximately 48%, or $194 M, from $402 M as of July 1, 2013 to $208 M as of June 30, 2014. OGB's FY 14 total expenditures grew 8.1% from FY 13, while its FY 14 total revenues decreased 1.4% from FY 13. OGB's overall 6-year trend of expenditure growth is still 6% annually, while its revenues have grown only 0.7% over that same 6-year time frame. As has been previously discussed, the main reason for the decrease in the OGB revenue growth is due to premium decreases of 7.11% in FY 13 and 1.8% in FY 14. Chart 1 below depicts an 8-year history of OGB's fund balance and the projected FY 15 ending year fund balance inclusive of DOA/OGB health plan changes.



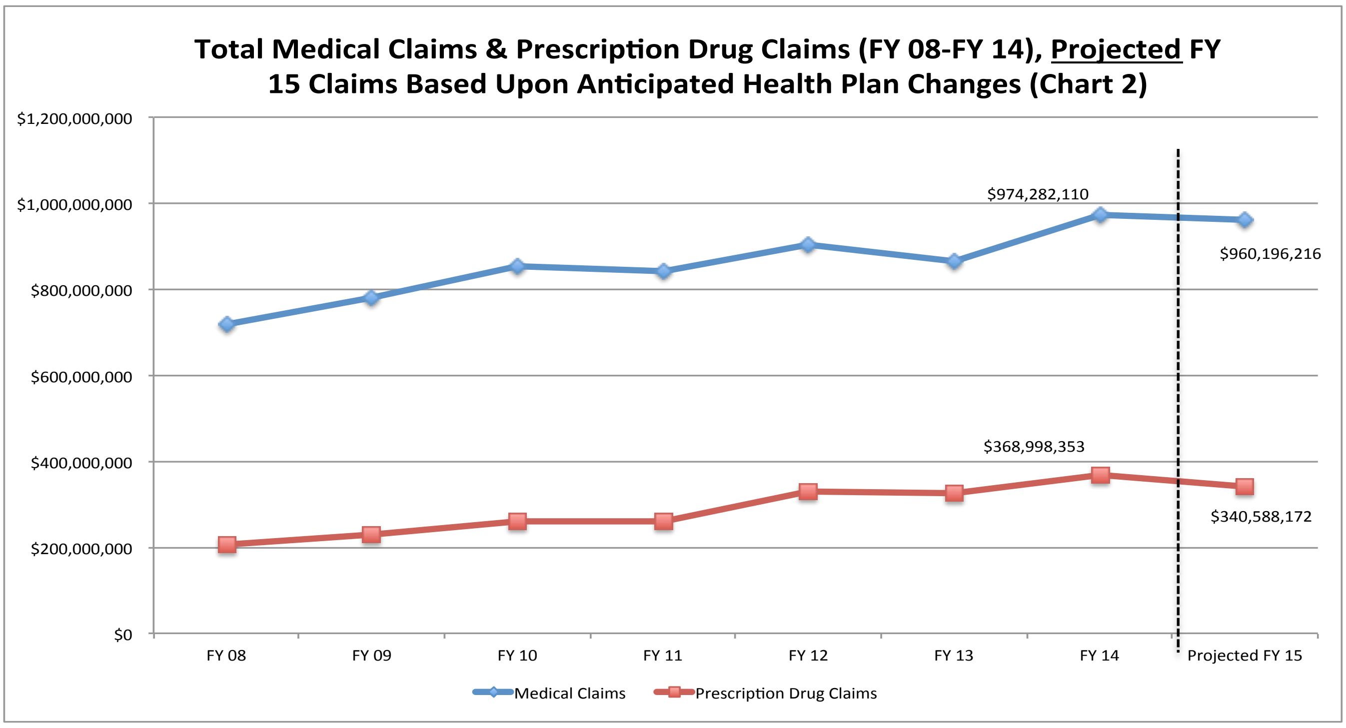
Using FY 14 actual revenue/expenditure data as the base year, to the extent FY 15 expenditures increase by the 6% trend and the anticipated savings actually occur from plan changes, the FY 15 ending year OGB fund balance would be approximately $119 M, which equates to a $7.4 M anticipated "negative monthly burn rate" in FY 15 (or $88.2 M annually) after health plan changes.

TABLE 1

FY 15 Projected Fund Balance	FY 13 Actual	FY 14 Actual	FY 15 w/6% Exp. Growth	FY 15 Health Plan Changes*	FY 15 Projected
Total Revenues	$1,263,912,119	$1,246,394,217	$1,246,394,217	$57,900,000	$1,304,294,217
Total Expenditures	$1,333,324,904	$1,440,672,343	$1,527,112,684	($134,600,000)	$1,392,512,684
Fund Balance Impact	($81,058,082)	($194,278,126)	($280,718,467)		***($88,218,467)***
Ending Year Fund Balance	**$401,745,025**	**$207,466,900**			***$119,248,433***

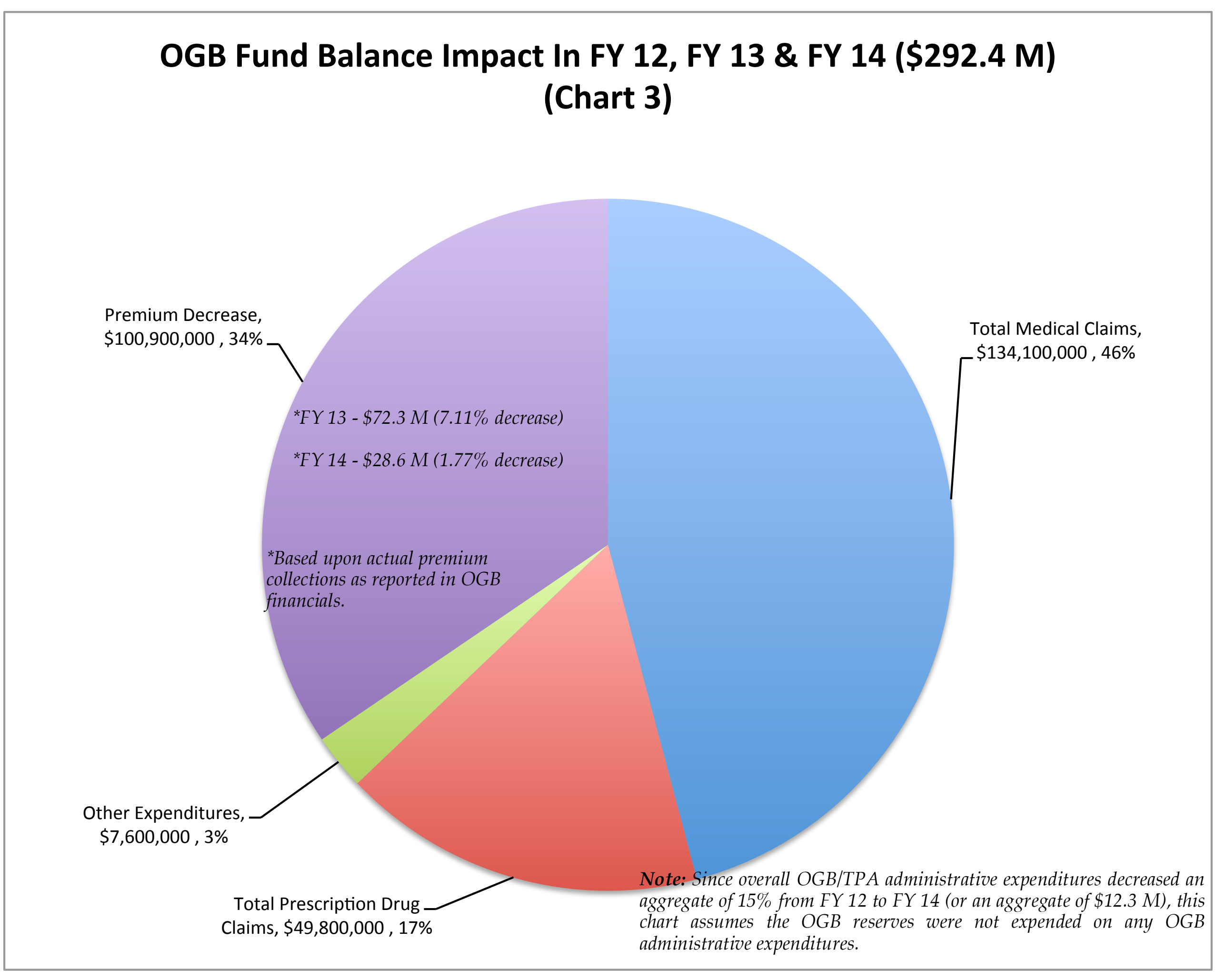
**The $57.9 M in revenues is due to the 5% premium rate increase effective July 1, 2014. The ($134.6 M) is based upon anticipated cost savings from the prescription drug changes in the amount of $69 M, other benefit reductions and health plan changes listed in Table 2 on page 2 in the aggregate amount of $62.8 M and anticipated administrative cost savings identified in the A&M Report due to the OGB reorganization in the amount of $2.8 M.*

Since the majority of the anticipated health plan changes will impact either medical claims or prescription drug claims, Chart 2 on the next page depicts the anticipated medical/prescription drug claims payments in FY 15 inclusive of plan changes. Assuming FY 15 medical and prescription drug claims increased by the 6-year trend (5% increase in medical, 11% increase in prescription drug) and the anticipated savings from the plan changes actually materialize in FY 15, the medical claims may decrease by 1% and prescription drug claims may decrease by 8%. These savings will result from: 1.) Decreased utilization, 2.) Increased member cost share (increased deductibles, out-of-pocket maximums, copayments and a prescription drug formulary).
***Note:** See page 8 of this document for an illustration of **only** increasing premiums to solve the negative burn rate as opposed to the combination approach that is being recommended by the DOA/OGB.*



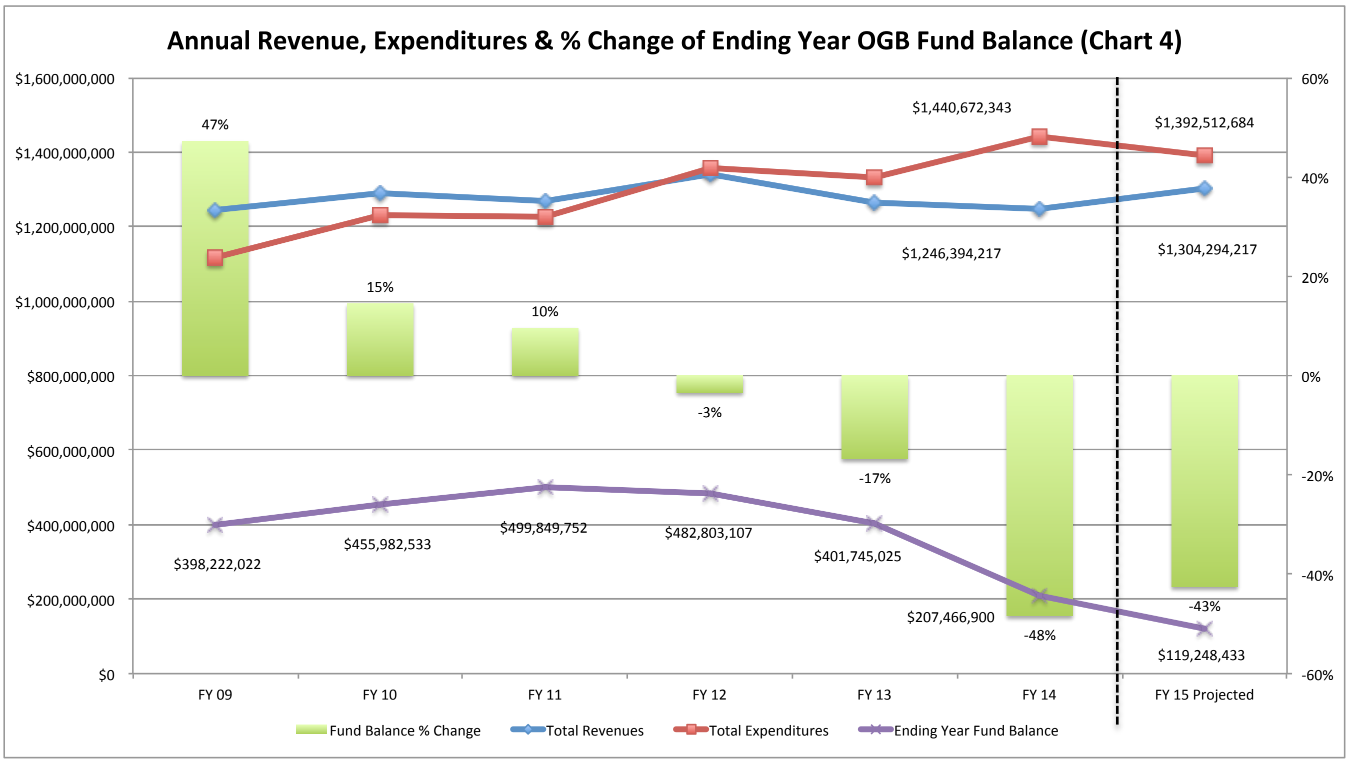
EXPENDITURES OF THE OGB RESERVES

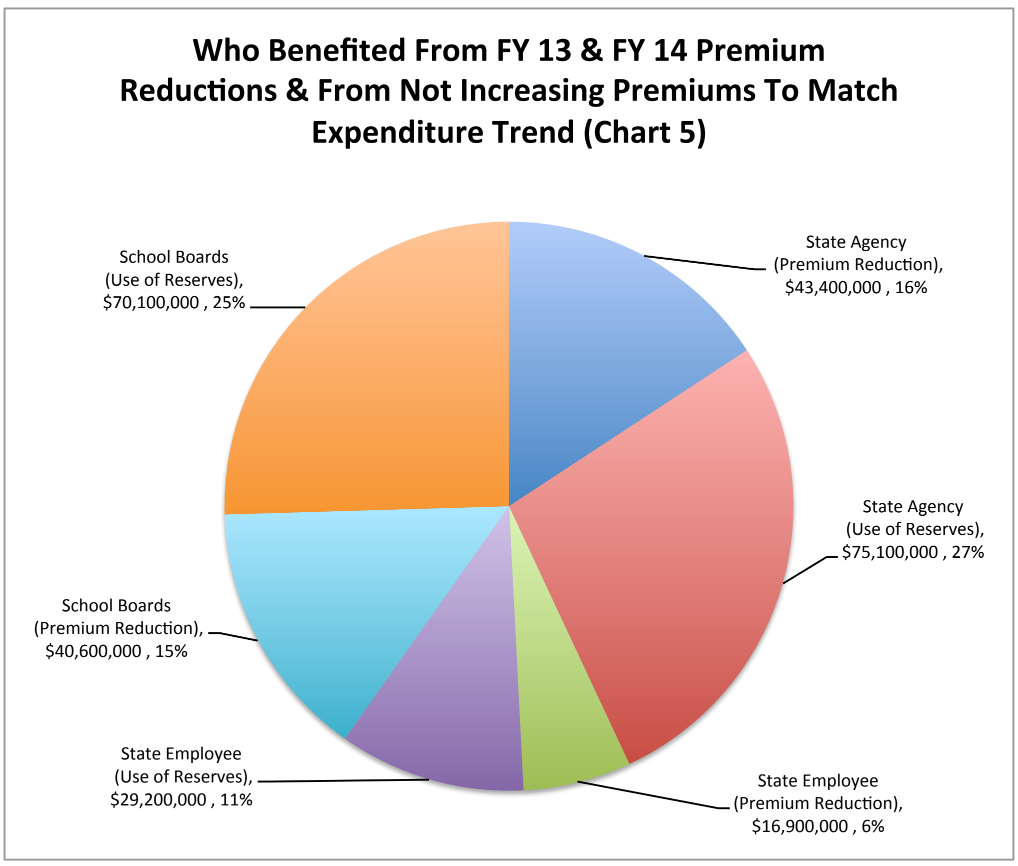
The FY 11 ending year fund balance was $499.8 M, while the FY 14 ending fund balance is $207.5 M. This equates to a $292.4 M reduction in the fund's reserves from the end of year FY 11 to the end of year FY 14. Since the OGB resources are *fungible*, it is difficult to calculate the specific expenditures paid by the fund. *Fungible* is defined as the state of being interchangeable, which means the original identity of the source of funding is lost when deposited into the OGB fund. One method to determine the expenditures of the $292.4 M reserves is to use a pro-rata share of prior year actual expenditures. From FY 12 to FY 14, OGB expended on average the following: 70% on Medical Claims, 26% on Prescription Drug Claims and 4% on Other Expenditures. These percentages were applied to $191.5 M, which is calculated as follows: $292.4 M (fund balance reduction) - $100.9 M (premium decrease) = $191.5 M. Since overall OGB/TPA administrative expenditures decreased an aggregate of 15% from FY 12 to FY 14 (or an aggregate decrease of $12.3 M), Chart 3 below assumes the OGB reserves were not expended on any OGB administrative expenditures. ***Note:*** *There are different methods to calculate the expenses of the $292.4 M reserve expenditures over a 3-year timeframe (FY 12, FY 13, FY 14). Chart 3 below is one example of how this information can be presented.*



WHO BENEFITED FROM PREMIUM REDUCTIONS?

As has been previously discussed, Chart 4 on the next page depicts that OGB's expenditures in FY 12 began to be higher than the amount of revenues being collected by the program, which resulted in





the OGB program living on reserves. The green bars in Chart 4 represent the percent change in the OGB's overall fund balance amount by fiscal year. Along with increasing expenditures, another reason for the decrease in the OGB fund balance during these fiscal years is due to premium reductions of 7.11% in FY 13 and 1.77% in FY 14. The state, state employees and school boards all benefited from these premium reductions. Based upon OGB FY 13 and FY 14 financials, the premium decreases have resulted in a total revenue loss of approximately $100.9 M ($72.3 M – FY 13, $28.6 M – FY 14), while the remaining fund balance depletion is due to average annual expenditure trend increase of approximately 6% not being funded through premium increases.

Based upon OGB historical pro-rata share percentages among state agencies, state employees and school boards, the benefit of the rate decreases and by not increasing premiums to fund expenditure trend is depicted in Chart 5.

Note: *The aggregate fund balance depletion from the FY 12 ending year balance to the FY 14 ending year balance is approximately $275.3 M. This depletion occurred during FY 13 and FY 14, which are the fiscal years during which the premium decreases were implemented. The FY 12 ending year fund balance was $482.8 M. The fund balance was $499.8 M at the end of FY 11. The $17 M difference between the FY 11 ending year fund balance and the FY 12 ending year fund balance is the negative 3% change in fund balance as depicted within the chart above (green bars). This reduction within the fund balance occurred prior to the implementation of the premium decreases.*

Chart 5 demonstrates that state agencies, state employees and school boards (employees/local school board entities) all benefited from the premium reductions. The total benefit depicted in Chart 5 in the amount of $275.3 M (aggregate fund balance change from ending FY 12 to ending FY 14) represents a net benefit from premium reductions in the amount of $100.9 M and the net benefit of using reserves in the amount of $174.4 M instead of funding the average expenditure trend increase with premium increases.

AMENDMENTS TO ACT 13 (HB 1) OF 2012 REGULAR LEGISLATIVE SESSION

Although there is no specific language in any prior year appropriations bill (Act 13 of 2012 RLS, Act 14 of 2013 RLS) or funds bill that directs the State Treasurer to transfer funds from the Office of Group Benefits into other state funds for expenditure, by not funding OGB's anticipated growth in expenditures (average of 6% annually) and by reducing premiums an aggregate 8.88% (7.11% + 1.77%=8.88%) within a 2-year timeframe, OGB was required to expend its reserve to pay for its expenditures. <u>This method reduced overall state expenditures within the budget, which resulted in funding becoming available for other purposes</u>. For example, language contained in Act 13 of 2012 (HB 1 –Section 18(D)), which is the budget for FY 13, reads as follows: *The commissioner of administration is hereby authorized and directed to reduce the State General Fund (Direct) appropriations contained in each department and budget unit contained in this Act and the Ancillary Appropriations Act for the office of group benefits for annual premium rate decreases to achieve a State General Fund (Direct) savings of not less than $22,000,000.* This language is due to the 7.11% premium decrease effective July 1, 2012 (FY 13 budget), which allowed $22 M of SGF resources to be used in other areas of the state budget.

Note: *R.S. 42:854 (C) provides that OGB's fund balance may not be utilized for the state's operating budget. Notwithstanding any other provision of law to the contrary, any money received by or under the control of the Office of Group Benefits shall not be used, loaned or borrowed by the state for cash flow purposes or any other purpose inconsistent with the purposes of the proper administration of the Office of Group Benefits.*

Note: *Based upon FY 13 actual revenue collections, the 7.11% premium reduction resulted in a total loss of premium revenues to the OGB in the amount of $72.3 M.*

Note: *A House Appropriations Committee Amendment to HB 1 during the 2012 Regular Legislative Session provided for SGF savings of $10.2 M and a Senate Finance Committee Amendment provided for an additional $11.8 M of SGF savings for a total of $22 M. These savings are attributable to the 7.11% premium decrease effective in FY 13.*

The FY 14 1.77% premium reduction was built into the Executive Budget. Based upon the Executive Budget documents and reviewing all group benefits budgetary adjustments, this premium reduction resulted in SGF savings of approximately $7 M. Based upon OGB FY 13 and FY 14 financials, the premium decreases resulted in a total revenue loss of approximately $100.9 M ($72.3 M – FY 13, $28.6 M – FY 14) of which a total of $29 M may be attributed to SGF.

PROJECTED FISCAL IMPACT OF HEALTH PLAN CHANGES

Due to the current negative monthly "burn rate" of $16.2 M, the Office of Group Benefits (OGB) is implementing various health plan changes. As has been previously discussed by the LFO, all of these changes are anticipated to result in approximately $190 M of annualized OGB savings in FY 15. Table 2 below is a listing of the changes and the anticipated dollar savings associated with each change. ***Note:*** *Specific details of these changes have been discussed in previous LFO reports to the JLCB.* Approximately 90% of the anticipated savings is due to 3 items. These items include: 5% premium increase - $57.9 M (31%), health plan design changes (changing health plan option choices) - $44.7 M (24%) and prescription drug changes (drug formulary) - $69 M (36%).

ALL OGB PLAN CHANGES (in millions) (Table 2)	FY 15
BCBS Medical - Prior Authorization	$1.0
BCBS Medical - Benefit Limits	$1.7
Rx-Formulary Design	$21.5
Rx-Formulary Design Conversion	$21.7
Rx-90 Fill option	$9.0
Rx-Clinical Utilization	$10.8
Rx-High Compound Mgmt	$3.4
Rx-Over Utilization Mgmt	$1.2
Rx-Acetaminophen Mgmt	$1.1
Rx-Polypharmacy Mgmt	$0.1
Rx-Exclude Medical Food	$0.2
Premium Increase (Additional Revenue) (Effective July 1, 2014)	$57.9
BCBS Medical-Plan Design	**$44.7**
BCBS Medical-Remove Vision	$5.3
BCBS Medical-Remove Standard Excluded Benefits*	$0.5
Communicate Health Retiree Medicare Exchange Option	$9.6
TOTAL	**$189.7**

Total prescription drug changes equate to $69 M.

**Examples of standard excluded benefits include: TMJ, acupuncture, impacted teeth, prior authorization of massages.*

As is indicated in Table 2 above, the DOA/OGB anticipates the health plan design changes to result in total annual OGB programmatic savings of $44.7 M. These savings will materialize in two distinct ways:

- ***Utilization will likely decrease*** – Based upon academic studies, if more OGB members enroll in the consumer driven plan options (HRA 1000, HSA 775), the members will likely become more aware of the cost of medical services and/or prescription drugs and could change behavior. This may result in an overall OGB medical claims cost decrease as members with these plans know and understand they only have finite resources (HSA/HRA account) to consume healthcare. This may result in more cost-effective healthcare decisions by the member. However, this anticipated outcome needs to be balanced against plan members potentially not going to the doctor due to lack of HRA/HSA funds available for care, which could result in medical costs in the future.

- ***Cost shift*** **–** By increasing deductibles, increasing the out-of-pocket maximum and increasing copayments, the new health plan options will significantly reduce the cost to OGB, while the OGB member pays more for medical services.

OGB MEMBER TOTAL COST EXPOSURE

The total potential cost to the OGB member is calculated based upon the total annual premiums paid and the total health plans' out-of-pocket maximum. Table 3 and Table 4 compare the current plan options to the proposed plan options relative to total out-of-pocket costs for active single and family. These tables represent the potential maximum cost exposure to the OGB member. To the extent the individual's (or family) utilization is not significant, the out-of-pocket maximum increase being proposed would have a minimal impact. However, as has been reported in previous LFO OGB reports, these tables illustrate significant expenditure exposure to the OGB member, which is greater under the proposed health plan options than current plan options.

TABLE 3 (ACTIVE SINGLE)

Active SINGLE	Annual Premiums Paid	Out-of-pocket Maximum	Total Potential Costs
Current HMO Plan	$1,683	$1,000	$2,683
Current PPO Plan	$1,782	$1,500	$3,282
Proposed HRA 1000*	$1,182	$4,000	$5,182
Proposed HSA 775**	$1,259	$4,225	$5,484
Proposed Local	$1,604	$3,000	$4,604
Proposed Local Plus	$1,684	$3,000	$4,684
Proposed Open Access	$1,782	$3,000	$4,782

TABLE 4 (ACTIVE FAMILY)

Active FAMILY	Annual Premiums Paid	Out-of-pocket Maximum	Total Potential Costs
Current HMO Plan	$5,858	$3,000	$8,858
Current PPO Plan*	$6,202	$5,500	$11,702
Proposed HRA 1000*	$4,114	$8,000	$12,114
Proposed HSA 775**	$2,955	$9,225	$12,180
Proposed Local	$5,582	$9,000	$14,582
Proposed Local Plus	$5,858	$9,000	$14,858
Proposed Open Access	$6,202	$9,000	$15,202

**The out-of-pocket maximum for the HRA 1000 plan is $5,000 active ($10,000 family). Due to the state providing $1,000 for an active ($2,000 family) in an HRA to pay for health services, the net out-of-pocket max is less.*
***The out-of-pocket maximum for the HSA 775 plan is $5,000 active ($10,000 family). Due to the state providing $200, plus a $575 dollar-for-dollar state match to the account to pay for health services, the net out-of-pocket max is less. Also, these tables assume the individuals/family will put $575 of additional resources into the HSA. This additional $575 is accounted for in the "premiums paid" column of the tables.*
****Current PPO Family plan is a family of 4 in table above.*

Another Perspective

According to the DOA/OGB, of the total HMO members, in plan year 2013 approximately 7% had an in-patient hospital stay and an aggregate 3% reached the current out-of-pocket maximum. The DOA/OGB contends these increases in the out-of-pocket maximums would only impact a small number of the total OGB population, which consists of approximately 230,000 lives.

CONSUMER DRIVEN HEALTH PLANS

Two of the proposed statewide health plan options are *consumer driven health plans*. The HSA 775 plan has a Health Savings Account (HSA), while the HRA 1000 plan has a Health Reimbursement Arrangement (HRA). These plans came into existence in 2002 (IRS Ruling on HRAs) and in 2003 as HSAs were created within the Federal Medicare Modernization Act. Since the OGB default health plan (if an OGB member does not make a plan selection) is the HRA 1000 and due to the premium structure of the new plan offerings financially incentivizing members to move to these consumer driven type plans, the LFO will present two different perspectives of these health plan designs.

Perspective #1: Consumer driven health plans are built around high-deductible insurance products and have price-sensitive demand for medical services (Buchmueller, 2009). ***Note:*** *All resources utilized for this analysis are listed on page 9*. Proponents of these health plan types argue that patients will be "more prudent purchasers of health care by giving them 'skin in the game'"(Buchmueller, 2009). The overall trend of consumer driven health plans has been gradually increasing in the private sector. According to the January 2014 health insurance census conducted by *American Health Insurance Plans (AHIP) Center for Policy and Research*, HSA qualified enrollment has increased from approximately 3.2 million individuals in January 2006 to 17.4 million in January 2014. For context, according to health plan data from the Kaiser Family Foundation, in 2012 there are a total of 170 million individuals covered by private/public sector health insurance (non-Medicaid/non-Medicare). Based upon the AHIP survey report, consumer driven plans cover approximately 10% of that population. Also, these plan types are now starting to be offered in the public sector as is reported in the *State Employee Health Plan Spending Report* by the PEW Charitable Trusts. There are now 19 state governments that offer these plan types to their employees. ***Note:*** *OGB currently offers a consumer driven plan (CDHSA). However, only 0.14% (or 350) of the current OGB population is enrolled.*

Since consumer driven plans are designed so that, except for catastrophic expenses, employees have some responsibility of paying their own health-care costs with these accounts (HRA/HSA), the idea of *consumerism* enters into the patient's decision making (Barro, 2011). Consumerism is "the tendency of consumer-directed health-plan members to spend health dollars more judiciously" (Barro, 2011). The idea is since the patient has more *skin in the game*, the patient will make healthcare decisions differently with the added financial disincentive.

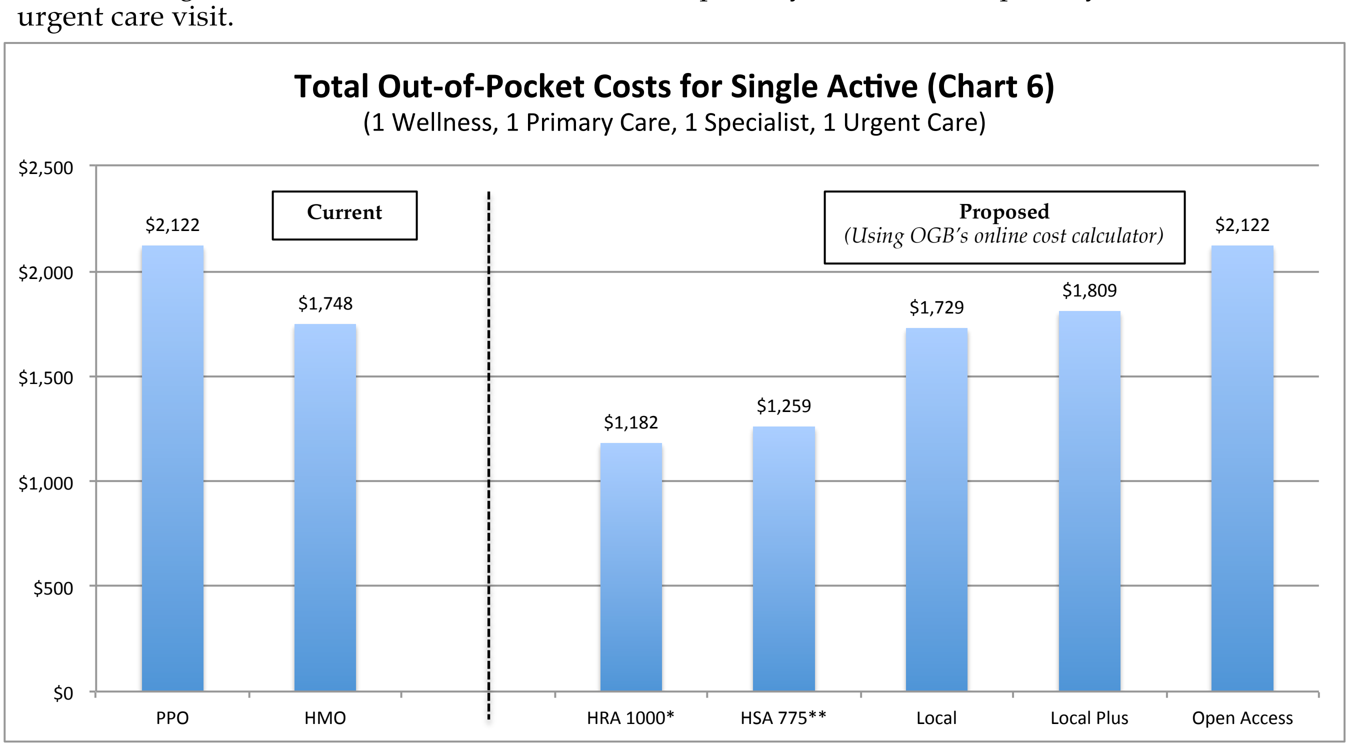
Perspective #2: According to the Centers for Disease Control (CDC), chronic conditions are responsible for 75% of health care costs. Consequently, there is legitimate concern that patients with chronic conditions may not choose a consumer driven health plan. According to a study published in the December 2013 edition of the *American Journal of Managed Care*, patients that moved from a traditional health plan to a consumer driven plan with an HSA had reduced prescription drug adherence for prevalent chronic conditions. The study evaluated the impact of moving from a traditional health plan to a consumer driven health plan for medication adherence of individuals with chronic conditions. The study indicated, "increased patient cost-sharing is associated with decreased health services utilization" (Fronstin et al, 2013). Basically, use of prescription drugs by individuals with chronic conditions declined when patients became subjected to higher out-of-pocket costs.

Other academic studies and surveys completed depict that consumer driven health plans may result in patients "skipping a recommended doctor's visit" (Iskarpatyoti, 2010). Other studies have shown that "patients with higher deductibles cut back on visits, tests, prescription drugs and specialist care" (Geyman, 2012). Skipping recommended visits may result in future unintended indeterminable medical costs in subsequent years. Since the majority of consumer driven health plans typically attract healthier populations through adverse selection, this specific unintended consequence has been difficult to prove empirically. Overall, opponents of these plan types argue that due to the "greater exposure to out-of-pocket costs," patients could be discouraged from seeking care (Charlton et al, 2011).

Consumer Driven Plan Conclusion
Both perspectives of consumer driven health plans are reflected in academic studies and research. There is no consensus among the academic community as to the impact on utilization and health care costs as a result of these plan types. However, if more individuals within the OGB enroll within these plans, overall medical service utilization could be reduced. As the plan members enroll within these plans, the members will be required to pay higher deductibles, coinsurance and out-of-pocket maximums and behavior could change from either not seeking care, delaying care or potentially modifying recommended care to the less costly option. Although the potential does exist for participating members in these consumer driven plans to build up personal reserves through HRA/HSA contributions, there may be a potential financial risk to the member in year 1 from switching from a traditional plan to a consumer driven plan if an unforeseen health event occurs during that year.

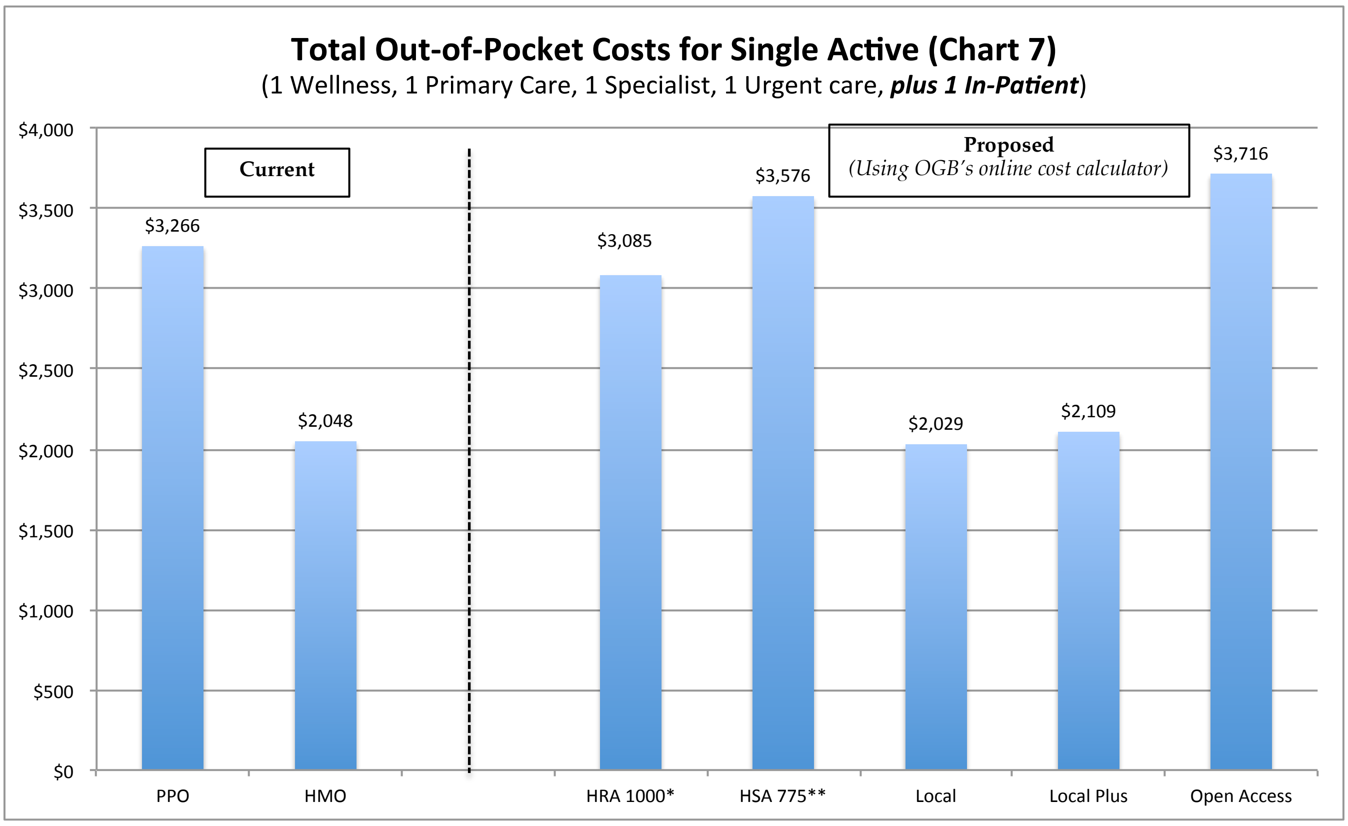
RISK IN SELECTING A HEALTH PLAN

Although the new health plan options significantly increase the out-of-pocket maximums compared to current health plan offerings, if the OGB member and dependents are not significant users of medical services, selecting a consumer driven health plan (discussed above) may save the member overall total out-of-pocket costs. However, there may be a potential financial risk to the member in year 1 when switching from a traditional plan to a consumer driven plan if an unforeseen health event occurs during that first year. See bar charts below that utilize the OGB's scenario calculator to illustrate the level of risk taken. Chart 6 calculates the total out-of-pocket costs of an active single for the following medical services: 1 wellness visit, 1 primary care visit, 1 specialty care visit and 1 urgent care visit.



**The HRA 1000 plan provides a member $1,000 ($2,000 family) to offset medical costs. This offset has been included in the charts below.*
***The HRA 775 plan provides an active member $200 and up to a $575 dollar-for-dollar match to be deposited into the members health savings account. The chart assume the member will at least deposit the $575 into the HSA in order to receive the state match.*
***Note:** These notes pertain to Chart 4 on the next page as well.*

Based upon Chart 6 above, if an individual merely has traditional routine medical service needs, it is possible for this individual to save total costs with a consumer driven plan as opposed to the current traditional plans and proposed traditional plans. However, Chart 7 on the next page reflects the total out-of-pocket costs with the same routine medical services provided, but additionally includes an in-patient hospital stay.



Based upon Chart 7, by including the in-patient hospital stay along with routine medical services, the consumer driven plan options are more costly to the member. However, the DOA/OGB contends that because only 7% of the current HMO population experience in-patient stays, the odds may be in member's favor if a consumer driven plan is chosen. For every year of low utilization there will be more resources available to the member in the HRA/HSA accounts to offset these costs because these funds can be carried forward from health plan year to health plan year. Based upon the single active scenario previously discussed, the risk to the OGB member within this illustration is approximately $1,000 to $2,000 of potential additional out-of-pocket medical expenses versus a gain of $500 to $1,000.

Under a similar scenario for an active family of 4, the potential cost savings of having a *good health plan year* ranges from $2,000 to $4,500 depending upon plan comparisons, while the risk of choosing a consumer driven health plan equates to a potential cost increase of $1,400 to $3,200. This risk assessment assumes only 1 member of a family of 4 has an in-patient hospital stay.

OPTIONS UTILIZED BY OGB

In order to manage a self-insured group health insurance plan there are 7 major items that can be modified to assist in the management of the plan. These items include: raising premiums, modifying benefits, increasing the employee cost share, reducing provider rates (network administration), producing better health outcomes (wellness initiatives), decreasing utilization and reducing administrative overhead. Based upon the proposed health plan changes, the DOA/OGB is incorporating a multi-step approach to stop the current negative monthly burn rate. Table 5 below provides a brief summary of the options already implemented by the DOA/OGB as well as the options being implemented effective January 1, 2015. As previously discussed, <u>even after all the anticipated health plan changes are implemented, the negative burn rate for FY 15 is anticipated to be $7.4 M, or an annualized negative fund balance impact of $88.2 M</u>.

OPTIONS UTILIZED BY DOA/OGB (Table 5)

Self-Insurance Health Plan Options	Description
Raise Premiums	Effective July 1, 2014, premiums increased by 5% which resulted in additional revenues in the amount of $57.9 M flowing into the OGB.
Modification of Benefits such as eliminating routine vision	Some benefit changes include: eliminating routine vision benefits and limiting out-of-network benefits (2 of 6 health plan options) all effective January 1, 2015.
Increase Cost Share	Increasing out-of-pocket maximums and copayments for health plans effective January 1, 2015. Also, implementing a 3-tier drug formulary effective August 1, 2015 that includes a reduced generic drug costs and an increased brand name drug cost.
Reduce Provider Rates	According to the DOA, this occurred when Blue Cross Blue Shield (BCBS) took over the administrative functions of the HMO Plan and PPO Plan. According to the DOA, BCBS has lower provider discounts to the member than the original OGB PPO provider network or the former HMO/EPO administrators could provide.
Better Health Outcomes	OGB has begun implementing their wellness initiatives.
Decrease Utilization	To the extent more members join consumer driven plans and due to higher cost share, consumerism will likely enter into the member's mind when making healthcare decisions for medical care and prescription drug choices, which may decrease overall utilization.
Administrative Overhead	Based upon the latest OGB financials, the Third Party Administrator (TPA) arrangement with Blue Cross Blue Shield (BCBS) for the operation of the PPO Plan to date has reduced overall administrative costs by approximately 15%. Based upon the FY 14 ending year financials, OGB's overall administrative overhead is approximately 4.7% of total expenditures, which is a decrease from administrative overhead of 6.1%, 5.9%and 5.4% in FY 11, FY 12 and FY 13.

ALTERNATIVE OPTION

Fiscal Impact of Just A Premium Increase

One option that has been requested of the LFO is to determine the impact of solving the current negative monthly burn rate with premium increases exclusively. Based upon the current expenditure increase trend of 6% annually and using actual FY 14 base expenditure data, the negative monthly burn rate would increase to $18.6 M/month in FY 15, which equates to a $223 M annualized FY 15 negative fund balance problem. Utilizing these numbers, in order to generate enough premiums to completely offset the anticipated negative burn rate premiums would have to be increased by another 18%, which would generate approximately $223 M in additional revenues. Pursuant to R.S. 42:851, the state (employer) is responsible for 75% of the premium while the employee is responsible for 25% of the premium. For members' dependents, the state is responsible for 50% of the premium and the employee is responsible for the remainder. The current blended employer/employee premium share is approximately 67% state/33% employee.

For **illustrative purposes only**, to the extent premiums are increased another 18% in FY 15, state agencies would be responsible for approximately $96 M of which a significant portion would likely have to be funded with SGF. The remaining portions would come from state employees in the amount of $37.3 M (or $13 per member per month) and from participating school boards in the amount of $89.7 M. The 18% premium increase would be in addition to the 5% premium increase that was effective July 1, 2014. To the extent this actually occurred, OGB members would experience an aggregate 23% premium increase in FY 15.

Note: *The breakdown of the state agency, employee and school board is based upon the percentage breakdown of the 5% premium increase that went into effect on July 1, 2014. This is merely an illustration and may not necessarily reflect the specific fiscal impact of this option.*

Note: *This illustration does not include any potential programmatic savings being incurred from the August 1, 2014 changes. To the extent these savings were included in the illustration above, the 18% premium increase calculation would likely be reduced.*

To the extent the 18% premium increase is paid entirely by the OGB member, based upon the current OGB enrollment data, the per member per month increase equates to approximately $80 per member per month (or $963 per member per year). This likely would require an amendment to R.S. 42:851.

POTENTIAL FY 16 PREMIUM RATE INCREASE

Since the JLCB meeting on September 19, 2014, the LFO has been requested to determine the potential premium increase that may be implemented beginning in FY 16 if all the health plan changes proposed by the DOA/OGB actually result in the projected savings. As has been previously discussed, after all the health plan changes are implemented, OGB's anticipated FY 15 ending year fund balance will be approximately $88.2 M less than the FY 14 ending year fund balance. Based upon the current projections from the health plan changes and based upon FY 14 actuals, premiums would have to be increased by 7.2% in FY 16 to completely stop the anticipated FY 15 negative burn rate of $7.4 M per month.

For **illustrative purposes**, to the extent premiums are increased 7.2% beginning July 1, 2015 (FY 16), state agencies would be responsible for approximately $38.4 M of which a significant portion would likely require SGF resources. The remaining portions would come from state employees in the amount of $14.9 M (or $5 per member per month) and from participating school boards in the mount of $35.9 M.

Sources of Information

American Health Insurance Plans (AHIP) Center for Policy & Research. "January 2014 Census Shows 17.4 million Enrollees in Health Savings Account-Eligible High Deductible Health Plans." July 2014.

Barro, Josh. "Cadillac Coverage: The High Cost of Public Employee Health Benefits." Civic Report: Center for State & Local Leadership at The Manhattan Institute. 65, (2011): 1-9.

Buchmueller, Thomas. "Consumer-Oriented Health Care Reform Strategies: A Review of the Evidence on Managed Competition and Consumer-Direct Health Insurance." The Milbank Quarterly: A Multidisciplinary Journal of Population Health and Health Policy. 87.4, (2009): 820-841.

Charlton PhD, Mary, Barcey Levy, PhD, MD, Robin High, MBA, MA, John Schneider, PhD and John Brooks, PhD. "Effects of Health Savings Account—Eligible Plans on Utilization and Expenditures." The American Journal of Managed Care. 17.1, (2011): 79-86.

Centers for Disease Control and Prevention, "Chronic Diseases: The Power to Prevent, The Call to Control" (2009), http://www.cdc.gov/chronicdisease/resources/publications/aag/pdf/chronic.pdf

Fronstin PhD, Paul, Martin-J Sepulveda, MD, and Christopher Roebuck, PhD, MBA. "Medication Utilization and Adherence in a Health Savings Account-Eligible Plan." The American Journal of Managed Care. 19.12, (2013): 400-407.

Geyman, John. "Cost-Sharing Under Consumer-Driven Health Care Will Not Reform US Health Care." Journal of Law, Medicine & Ethics. Fall (2012): 574-581.

Iskarpatyoti, Lale. "What's Next for Consumer-Direct Health Plans?" Benefits Quarterly. First Quarter, (2010): 39-42.

Kaiser Family Foundation. "Health Insurance Coverage of Population." 2012.

PEW Charitable Trusts & MacArthur Foundation. "State Employee Health Plan Spending: An examination of premiums, cost drivers and policy approaches." August 2014.

Wilson, Amy, Eric Bargman, Derek Pederson, Annikka Wilson, Nancy Garrett, David Plocher and Philip Ailiff Jr. "Health Care Utilization in a Consumer-Driven Health Plan." Benefits Quarterly. First Quarter, (2008): 46-54.

HEALTH INSURANCE DEFINITIONS

Based upon research, the LFO has provided definitions of commonly used health insurance terms that are utilized throughout this document. The source of the prescription drug terms is from MedImpact's presentation to the OGB board on July 30, 2014. MedImpact is OGB's pharmacy benefit manager. This has been previously provided for review in the August 2014 LFO memo to the committee. This list is provided again for your use.

- ***Premium*** *– Amount of money a member pays monthly for health insurance.*
- ***Deductible*** *– Amount of money a member pays for eligible medical expenditures. After the deductible is met, the health plan pays 100% or the member shares the costs (coinsurance) with the health plan up to the out-of-pocket maximum (like the proposed OGB health plan options). The deductible is typically different for in-network and out-of-network providers. All new health plan options have different deductibles for in-network and out-of-network, excluding the Local/Local Plus health plans which have no out-of-network benefit at all.*
- ***Coinsurance*** *– Health cost sharing between the OGB member and the health plan. Cost share ranges included in the new OGB plan offerings range from 90/10 to 80/20, whereby the health plan pays either 90% or 80% of the medical service cost and the member pays the balance up to the out-of-pocket maximum.*
- ***Out-of-pocket Maximum*** *– The maximum amount of money an OGB member pays out-of-pocket for medical services in a health plan year. Under the OGB health plan offerings, co-pays, coinsurance and deductibles are all included in the out-of-pocket maximum calculation. The out-of-pocket maximum typically varies for in-network and out-of-network providers.*
- ***Health Savings Account (HSA)*** *– A savings account that is utilized in conjunction with a high deductible health insurance policy that allows an individual to save money tax-free in an account for medical expenses. Depending upon the employer policy, contributions are made to the account by the employer and employee and these funds can follow the employee.*
- ***Health Reimbursement Arrangement (HRA)*** *– An employer funded account that reimburses employees for out-of-pocket medical expenses. HRAs are notional accounts and the funds cannot follow the employee. In addition, only the employer can contribute to the account.*
- ***Generic Drugs*** *– Identical to a brand name drug in dosage, strength, effectiveness and safety.*
- ***Preferred Brand Drugs*** *– Drugs that have been on the market and do not have a generic equivalent available.*
- ***Non-preferred Brand Drugs*** *– Higher-cost medications that have recently come on the prescription drug market.*
- ***Specialty Medications*** *– Brand or generic drugs that cost over $600 and typically treat specific diseases such as Cancer, Multiple Sclerosis and Rheumatoid Arthritis.*
- ***Balanced Billing*** *– The practice of an out-of-network provider billing the health plan member the difference between the amount the health insurance plan pays (only if there is an out-of-network benefit) and the total medical services costs. If a health plan has an out-of-network benefit, it will only pay a percentage of what is known as "reasonable and customary" amount. If the health plan does not have an out-of-network benefit, the OGB member would be responsible for the entire medical costs of the out-of-network provider.*

STATE OF LOUISIANA

LEGISLATIVE FISCAL OFFICE
BATON ROUGE

Post Office Box 44097
Capitol Station
Baton Rouge, Louisiana 70804
Phone: 225.342.7233
Fax: 225.342.7243

John D. Carpenter
Legislative Fiscal Officer

TO: The Honorable James R. Fannin, Chairman Joint Legislative Committee on the Budget (JLCB)
The Honorable Jack Donahue, Vice Chairman Joint Legislative Committee on the Budget (JLCB)
Honorable Members of the Joint Legislative Committee on the Budget (JLCB)

FROM: John D. Carpenter, Legislative Fiscal Officer
J. Travis McIlwain, Section Director

DATE: August 11, 2014

SUBJECT: Office of Group Benefits (OGB) Update

The Legislative Fiscal Office (LFO) attended the OGB Policy & Planning Board meeting held on July 30, 2014. Along with multiple presentations from various vendors and the swearing in of new board members, OGB presented to the board the proposed health plan changes effective August 1, 2014 and January 1, 2015. A detailed explanation of the health plan changes and the fiscal impact of the changes are discussed below.

Since the FY 14 fiscal year's accounting cycle is not completed (August 15th is the deadline), the LFO has no additional OGB financial information to report to the committee relative to OGB's current fund balance. However, OGB's contract actuary provided a report to the OGB Policy & Planning Board that indicated the anticipated FY 14 ending year OGB fund balance to be approximately $218.4 M.

Note: Page 7 of this document includes a complete listing of health insurance terms utilized throughout this document.

HEALTH PLAN CHANGES

In order to slow the current OGB monthly "burn rate" of spending $16.1 M more than monthly revenue collections, OGB is modifying the health plan options for all state employees (and participating school board employees) and anticipating these changes to result in $44.7 M in overall expenditure savings and the prescription drug changes to result in an additional $69 M in expenditures savings all in FY 15.

The significant changes to the health plans include:

1.) ***Significantly increasing the out-of-pocket maximum for all health plan options;***
2.) ***Increasing deductibles for all health plan options;***
3.) ***Increasing co-pays 100% for those proposed health plans with co-pays;***
4.) ***Increasing the out-of-pocket maximum for the prescription drug benefit by $300 from $1,200 to $1,500 (20% increase);***
5.) ***Subjecting the prescription drug benefit to a drug formulary with various drug categories that will result in an increased cost for preferred and brand name drugs and a decreased cost for generic drugs;***
6.) ***Implementing other various prescription drug benefit changes including high compound management, over utilization management and the exclusion of medical foods;***
7.) ***Requiring prior authorizations for certain medical procedures;***
8.) ***Eliminating the out-of-network benefit for some health plan options, which could result in balanced billing for some OGB members depending upon the new health plan choice;***
9.) ***Application of standard benefit limits (Blue Cross Blue Shield standard) for skilled nursing facilities, home health care services and hospice care services;***
10.) ***Removing all vision coverage from the health plan options;***
11.) ***Implementing the Live Better Louisiana wellness initiative;***
12.) ***Decreasing premiums for the proposed HRA/HSA compared to the current Consumer Driven Health Savings Account (CDHSA) health plan option.***

The health plan and prescription drug plan policy changes listed above will shift more of the costs from the state (OGB Health Plan) to the OGB plan member and as mentioned above will save the state at least $44.7 M for health plan changes and at least $69 M for prescription drug plan changes in FY 15.

Along with premiums, the major costs incurred for medical services by an OGB plan member will be deductibles, co-payments and coinsurance. Table 1 on the next page is a brief summary

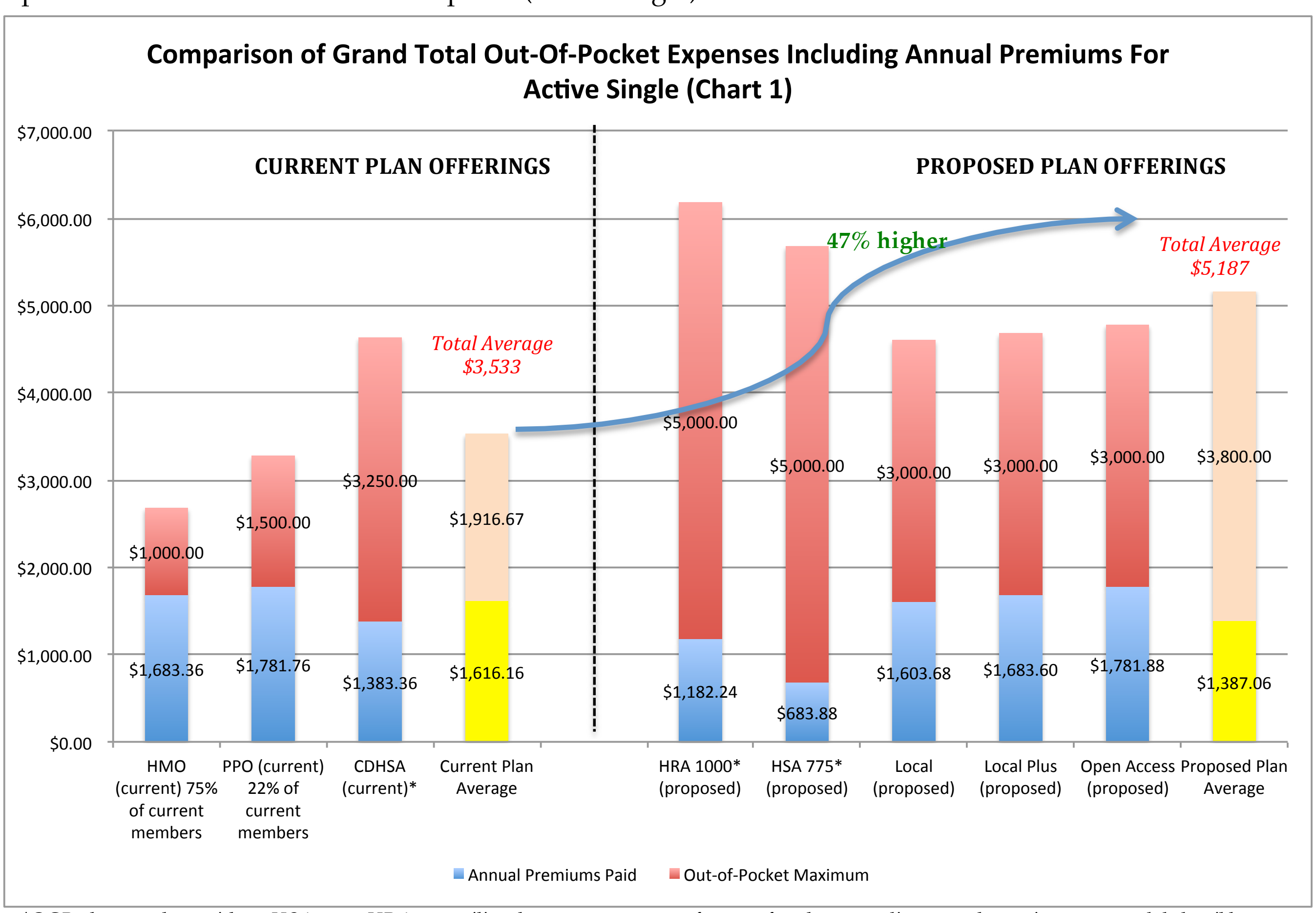
TABLE 1								
CURRENT OGB PLAN OFFERINGS				PROPOSED OGB PLAN OFFERINGS				
ACTIVE SINGLE	PPO	HMO	CDHSA	HRA 1000	HSA 775	Local	Local Plus	Open Access
Deductible*	$500	$0	$1,250	$2,000	$2,000	$500	$500	$1,000
Co-Pays	$0	$15/$25	$0	$0	$0	$25/$50	$25/$50	$0
Coinsurance	10%	$0	20%	20%	20%	$0	$0	10%
OOM (in-network)	$1,500	$1,000	$3,250	$5,000	$5,000	$3,000	$3,000	$3,000
OOM (out-of-network)	$3,500	$4,000	$3,250	$10,000	$10,000	N/A	N/A	$4,000
Out-of-Network Benefit	30%	30%	30%	40%	40%	N/A	N/A	30%

**The deductible listed in the Table 1 for the proposed plans is for in-network providers. There is a separate and higher deductible for out-of-network providers under the proposed health plans. The same is true for the out-of-pocket maximum.*

comparing the costs of the current major OGB health plan offerings to the proposed OGB health plan options for a Single Active Employee. Based upon Table 1, by adding and/or increasing deductibles, increasing the out-of-pocket maximum and increasing co-payments and coinsurance, the new health plan offerings will significantly reduce the cost to OGB, while the OGB member pays more for their medical services. As shown in Table 1, all new health plan options will have a deductible increase *(PPO plan currently has a $500 deductible for active single)*, an out-of-pocket maximum increase, a copay increase or incur the additional cost of having a deductible that currently does not exist for most OGB members. Of the total OGB population, 75% are currently enrolled in the HMO plan, which currently has a $0 deductible. Thus, the majority of OGB plan participants will be subject to a deductible and coinsurance whereas most are currently only subject to fixed co-pays.

Note: *Based upon Table 1 above, it appears there is not much difference between the current CDHSA plan and the proposed HRA 1000 and HSA 775 health plan choices. However, as of the latest OGB enrollment information, there are approximately 350 total covered lives (223 OGB members) that are currently covered by the current CDHSA plan. This represents 0.15% of the total OGB member population. Since the majority of OGB's member population is either in the PPO Plan (22%) or HMO Plan (75%), comparing the current CDHSA health plan to the new health plans will not illustrate the complete fiscal impact to the OGB program and its membership.*

Chart 1 below compares the total out-of-pocket costs (true costs) including annual premiums paid (denoted in the blue bars below) and the out-of-maximum (total amount member must pay before health plan pays 100% denoted in the red bars below) for all current and proposed health plans. The average out-of-pocket costs for all proposed health plans are 47% higher than the average out-of-pocket costs of the current health plans (active single).



**OGB plan members with an HSA or an HRA can utilize these accounts to pay for out-of-pocket expenditures such as coinsurance and deductibles.*

Based upon the new health plan offerings, the diagram on the next page is an illustration of how deductibles, coinsurance and out-of-pocket maximums work in relation to the new OGB health plan options that have deductibles and coinsurance. Due to the majority of OGB members being in the HMO plan without deductibles and coinsurance, these individuals will likely choose a plan with deductibles and coinsurance if the member wants a similar plan structure to the current HMO plan.

DURING OGB PLAN YEAR (JANUARY 1 THROUGH DECEMBER 31)

How Deductibles, Coinsurance and Out-of-Pocket Maximums will work for the proposed HRA 1000, HAS 775 and Open Access Plan members.

Deductible

OGB member pays 100% of the healthcare costs up to the amount of deductible. Deductibles range from $500 to $8,000 depending upon health plan choice, plan type (single, family) and if the deductible applies to an in-network or out-of-network provider.

***Note:* If the OGB member has the HRA 1000 or HSA 775 plans, the resources in their HSA or HRA can be utilized to pay the deductibles and coinsurance.**

***Note:* There are different out-of-pocket maximums and deducitibles for the out of network benefit portion of the health plan.**

STEP 1

Coinsurance

After the deductible is met, the OGB member will pay coinsurance % up to the out-of-pocket maximum. Coinsurance costs range from 80/20 to 90/10 depending upon health plan choice. For example, 80/20 coinsurance means the OGB member will pay 20% of the contracted rate while the health plan pays 80%. Proposed out-of-pocket maximums range from $3,000 to $20,000 depending upon health plan choice and plan type (single, family).

***Note:* There are some health plan choices that do not have coinsurance and only have co-pays (Local/Local Plus)**

***Note:* Along with the conisurance and co-pays, deductible payments go toward out-of-pocket maximum.**

STEP 2

100% Paid by Health Insurance Plan

After the OGB member has met the out-of-pocket maximum (through deductible, co-pay & coinsurance), the health insurance plan will pay 100% of the medical costs.

***Note:* The pharmacy benefit has a separate out-of-pocket maximum, which is being increased by $300 from $1,200 to $1,500 effective August 1, 2014 for all active and Non-Medicare Retirees. The prescription drug out-of-pocket maximum for Medicare Retirees will be effective on January 1, 2015.**

STEP 3

VARIOUS OGB SCENARIOS

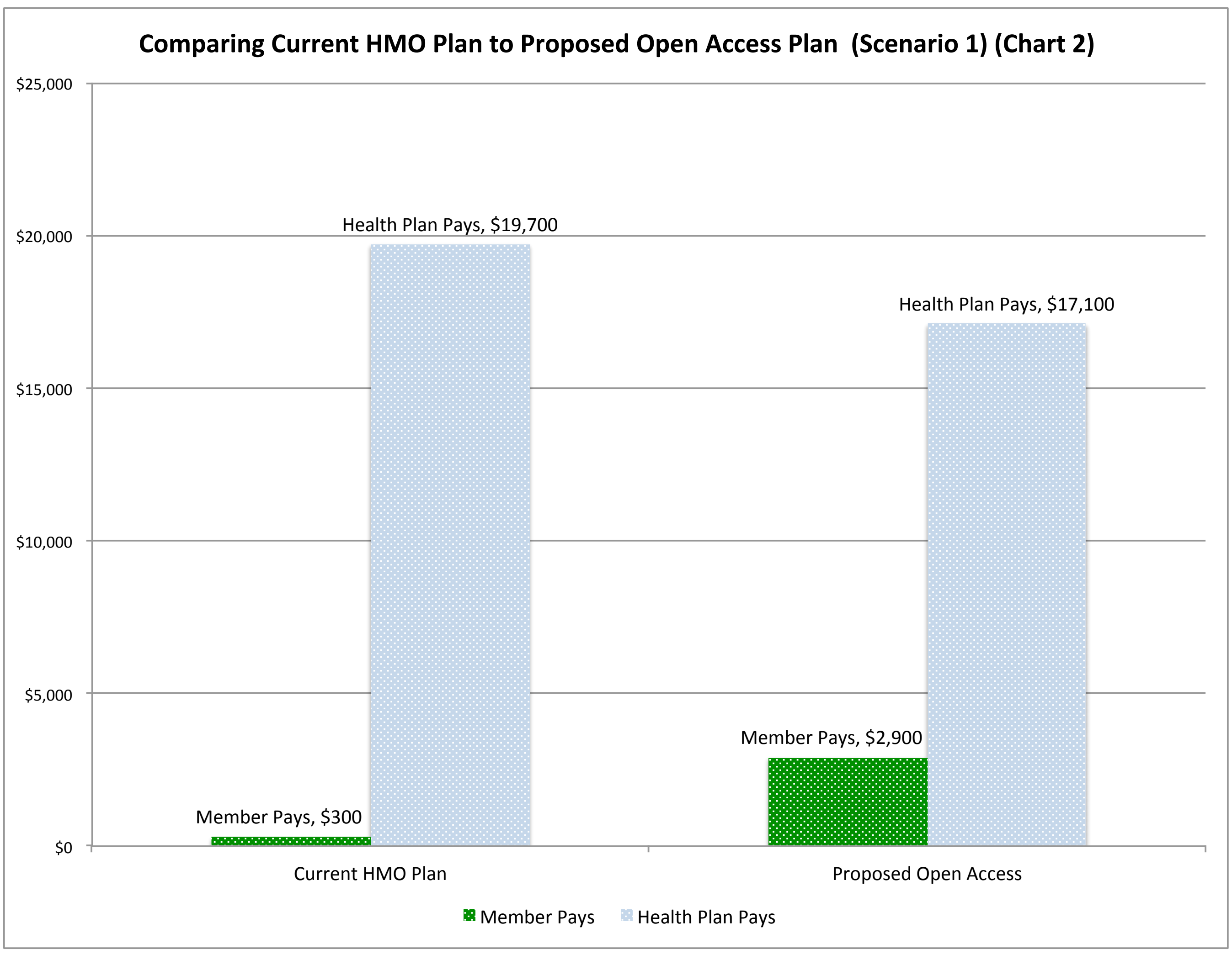
After reviewing the new health plan offerings presented to the board, the LFO has created a few scenarios to illustrate the cost saving potential to the OGB of the new health plan options compared to the existing plans. **These scenarios are based upon assumptions of the total contracted rate costs and assume all providers are in-network providers and facilities (hospitals) of the current Blue Cross Blue Shield Provider Network**.

Note: *For purposes of simplicity, all scenarios presented are for an active single member. A detailed and specific health plan comparison cannot be completed until the OGB/DOA releases the official proposed health plan documents of all five health plan options, which will not be made available until annual enrollment begins in October 2014. These scenarios are meant to assist in explaining the differences between the current plans and the proposed plans based upon OGB's presentation to the OGB board on July 30, 2014 and are in no way actuarially sound.*

Scenario 1: At the beginning of the health plan year, an individual (active single) breaks his foot and has to have emergency surgery. Due to the complexity of the procedure, the individual is required to stay in the hospital for 3 days following surgery and requires the assistance of home health services upon hospital discharge. For this scenario, the total cost of these medical services is $20,000, which is broken down as follows:

- $17,000 – emergency room plus 3 days inpatient hospital bill
- $3,000 – home health bill
- $20,000 – Total

Based upon the proposed health plan offerings for this scenario, the OGB program will save significant medical claim expenditures. See Chart 2 below that compares the current HMO plan to the proposed Open Access heath plan option. ***Note:*** *These two plans were picked for comparison because the majority of OGB members (75%) have the HMO Plan and the Open Access Plan is the only proposed health plan option that is a traditional health plan that also has an out-of-network benefit like the current HMO plan.*



Note: The current HMO plan requires co-payments while the proposed Open Access plan has deductibles and coinsurance.

Based upon Chart 2 above, the OGB health plan will decrease its financial expenditures from paying 98% of the medical costs to paying 86% of the medical costs. In this scenario, this represents a 13% decrease in OGB health plan expenditures, but also represents a significant out-of-pocket increase for OGB plan members.

***Scenario 2*:** An individual (active single) visits an ENT (Specialist) on January 2, 2015 for treatment of a severe sinus infection. Due to January 2 being the second day of the new health plan year, the entire cost of the doctor visit (assuming $600 for an ENT visit with in-house lab work) will be borne by the OGB plan member (dependent upon health plan choice), which will result in expenditure savings to the overall OGB program. See Table 2 that compares scenario 2 costs under current health plan options to proposed health plan options.

$600 ENT DOCTOR VISIT ON JANUARY 2nd (SCENARIO 2) (TABLE 2)								
	PPO	**HMO**	**CDHSA****	**HRA 1000****	**HSA 775****	**Local*****	**Local Plus*****	**Open Access**
Deductible	$500	$0	$1,250	$2,000	$2,000	$500	$500	$1,000
Copays	$0	$25	$0	$0	$0	$50	$50	$0
Coinsurance*	90/10	$0	80/20	80/20	80/20	$0	$0	90/10
ENT Visit Costs	**$600**	**$600**	**$600**	**$600**	**$600**	**$600**	**$600**	**$600**
Member Pays (deductibles, copays, coinsurance)*	($510)	($25)	($600)	($600)	($600)	($50)	($50)	($600)
Health Plan Pays	($90)	($575)	$0	$0	$0	($550)	($550)	$0

Coinsurance for the current **PPO plan is 90/10 once the deductible is met. Thus, under this scenario, a current PPO plan member would be responsible for paying the $500 deductible as well as 10% coinsurance of the remaining doctor visit cost, which equates to $10 in this scenario (10% of $100 = $10).*

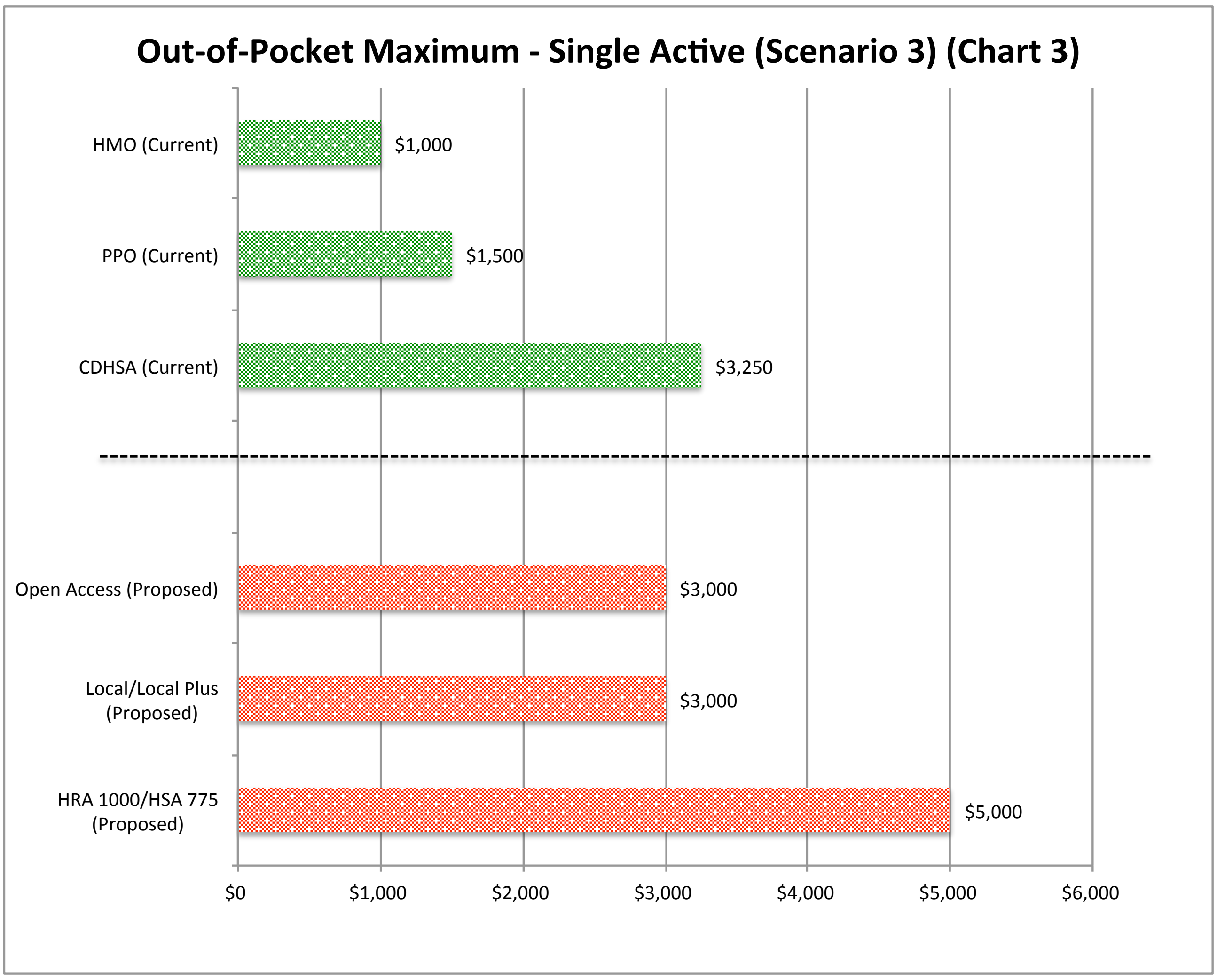
***If the OGB member has the HSA 775 or HRA 1000, the $600 ENT visit could be funded with resources contained within the members' HSA or HRA account. This is currently the case for those members who have the CDHSA account. There is currently 0.15% of OGB's member population who has the CDHSA plan.*

****These health plans only have an in-network benefit and no out-of-network benefit, which could result in the OGB member being **balanced billed** for medical services provided by providers outside the Blue Cross Blue Shield nationwide network for Local Plus plan option or the Blue Cross Blue Shield community network (Baton Rouge, Shreveport, New Orleans areas only) for the Local plan option. Balanced billing is the practice of an out-of-network provider billing the health plan member the difference between the amount the health insurance plan pays (only if there is an out-of-network benefit) and the total medical services costs. If a health plan has an out-of-network benefit, it will only pay a percentage of what is known as the "reasonable and customary" amount. **If your health plan does not have an out-of-network benefit, the health plan member would be responsible for the entire medical service cost of the out of network provider. See Table 3 below for an <u>out-of-network benefit comparison</u> of the health plan choices compared to current plans.***

TABLE 3		
Health Plans	**Out-of-Network Benefit (Yes or No)**	**Out-of-Network Benefit**
HMO Plan (Current)	YES	30% of fee schedule up to out-of-pocket maximum of $4,000 (individual) or $12,000 (family)
PPO Plan (Current)	YES	30% of fee schedule up to out-of-pocket maximum of $3,500 (individual) or $12,700 (family)
CD-HSA (Current)	YES	30% of fee schedule up to out-of-pocket maximum of $3,250 (individual) or $11,000 (family)
Local/Local Plus (Proposed)	NO	No Out-of-Network Benefit
Open Access (Proposed)	YES	$1,000 deductible (single), $3,000 deductible (family), 30% coinsurance up to out-of-pocket maximum of $4,000 (individual) or $12,000 (family)
HRA 1,000/HSA 775 (Proposed)	YES	$4,000 deductible (single), $8,000 deductible (family), 40% coinsurance up to out-of-pocket maximum of $10,000 (individual) or $20,000 (family)

***Scenario 3*:** The same individual (active single) visits the ENT (Specialist) again on December 30, 2015 for treatment of a similar severe sinus infection. Due to December 30th being at the end of the health plan year, the $600 visit (with in-house lab work) could be completely covered 100% by the health plan, if the active single individual has met the out-of-pocket maximum of the health plan. See Chart 3 on the next page that compares the out of pocket maximums for the current health plan options to the proposed health plan options before the plan covers 100% of an in-network providers' costs.

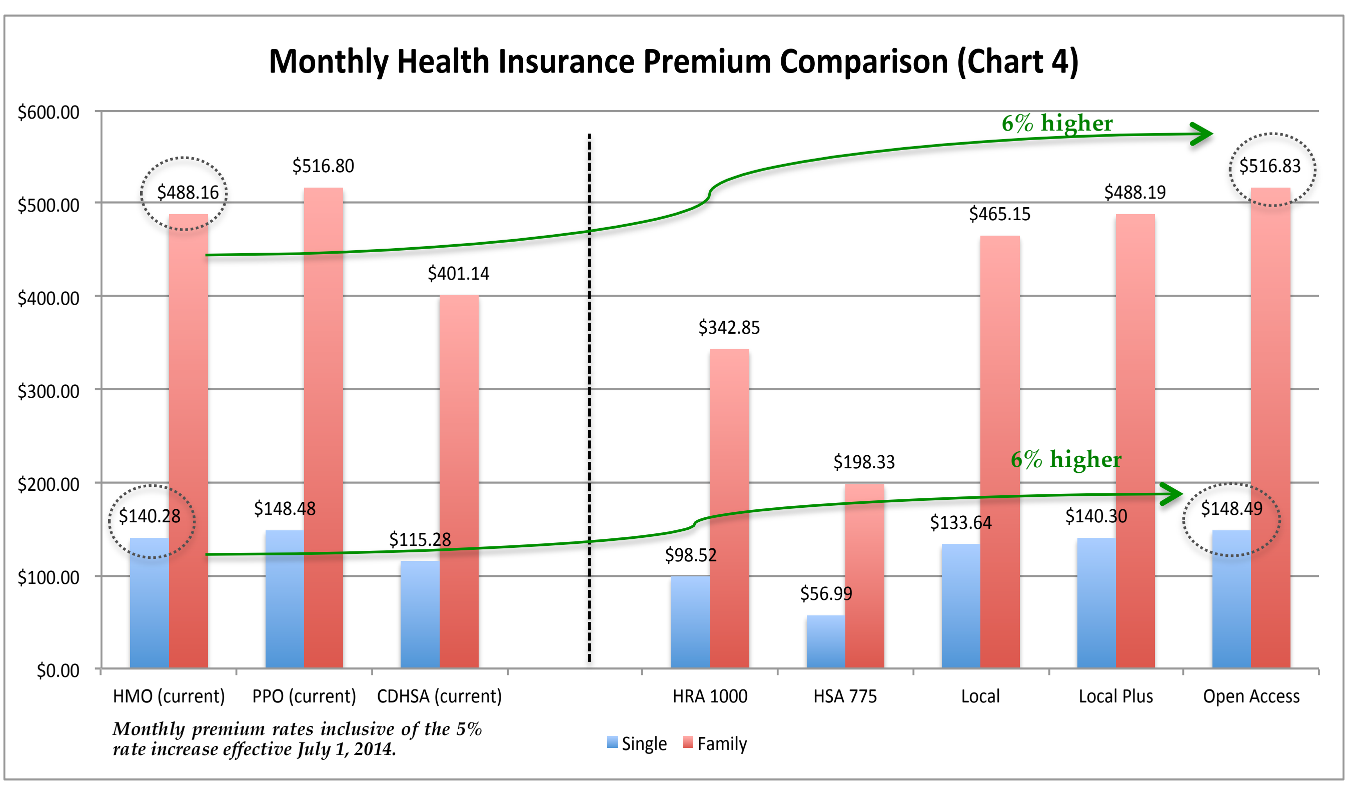
Based upon Chart 3 on the next page, the $600 ENT visit at the end of the health plan year will be 100% covered if the out-of-pocket maximum is reached. **<u>The out-of-pocket maximums for OGB plan members are significantly increased ranging from 54% increase (comparing current CDHSA to proposed HRA 1000/HSA 775) up to a 300% increase (comparing current HMO to proposed Open Access and Local Plus). This change will result in significant cost savings to OGB</u>.**



HEALTH PREMIUMS

Other than the HRA 1000 and HSA 775 (premiums will be lower than current CDHSA), the health premiums for the new health plan options will remain unchanged for January 1, 2015. **However, due to the majority of the current OGB plan members (75%) being under the HMO Plan, those individuals that choose the Open Access Plan, which is the only traditional health plan with both an in-network and out-of-network benefit like the current HMO plan, will pay approximately 6% more in premiums beginning January 1, 2015. Due to the 5% premium increase that was effective July 1, 2014 these specific OGB members will be subject to a total premium increase of 11% in FY 15 (See Chart 4 Below).** The Open Access plan premium mirrors the current PPO plan premium, which is currently 6% higher than the current HMO plan premium. OGB members who have the PPO plan and who pick the Open Access Plan would see no change in premium payments. See summary bullets and Chart 4 below.

- Proposed HRA 1000 and HRA 775 premiums are significantly lower than the current CDHSA plan option;
- Proposed Local Plus premiums are the same as current HMO plan option;
- Proposed Open Access premiums are the same as current PPO plan option.



PRESCRIPTION DRUG CHANGES

Effective August 1, 2014, the prescription drug benefit changed for all current (active/non-Medicare retirees) OGB plan members. The prescription drug benefit will be subject to a tiered drug formulary and the out-of-pocket maximum will increase $300 from $1,200 to $1,500 (20% increase). The OGB anticipates these changes, along with other prescription drug changes, will result in overall OGB expenditure savings in the amount of $69 M in FY 15.

A drug formulary is a list of medications available to health plan members under the health plan's drug benefit. The formulary consists of 4 different drug categories: generic drug, preferred brand drugs, non-preferred brand drugs and specialty medications. Table 4 below is comparison of the prescription drug benefit prior to the August 1st changes and after the August 1st changes.

TABLE 4		
Co-pay Before Out-Of-Pocket Is Met	**Prior to August 1st**	**Change**
Generic	50%, maximum $50 per month's supply	50%, maximum $30 per month's supply
Brand	50%, maximum $50 per month's supply	50%, maximum $55 per month's supply
Non-Preferred Brand	50%, maximum $50 per month's supply	65%, maximum $80 per month's supply
Specialty	50%, maximum $50	50%, maximum $80
Co-pay After Out-Of-Pocket Is Met	**Prior to August 1st**	**Change**
Generic	$0 per month's supply	No change
Brand	$15 per month's supply	$20 per month's supply
Non-Preferred Brand	$15 per month's supply	$40 per month's supply
Specialty	$15	$40

Based upon Table 4, the new prescription drug benefit changes incentivize OGB health plan members to purchase generic drugs as opposed to brand and/or non-preferred brand drugs.

Note: *The drug benefit changes effective August 1, 2014 will only impact Actives and non-Medicare retirees. The drug benefit changes will impact Medicare Retirees on January 1, 2015.*

Other prescription drug changes

In addition to implementing a tiered drug formulary and increasing the out-of-pocket maximum $300, OGB is implementing other prescription drug changes. OGB is anticipating the drug formulary changes to result in $43.2 M of FY 15 savings and the remaining $25.8 M in savings (for a total of $69 M) will come from the significant items listed below.

- *Clinical Utilization Management* – Require prior authorizations and quantity limits on prescription drugs ($10.8 M);
- *90 Day Fill Option* – For maintenance medications, 90-day prescriptions fills for 2.5 times the cost of your co-pay with a maximum of $75 ($9 M)
- *High Cost Compounds* – Require prior authorizations on high cost compounds over $400 ($3.4 M);
- *Over Utilization Management* – Identify OGB members receiving an equivalent greater than 120 mg/day of morphine or other narcotics being prescribed by multiple doctors and filled at multiple pharmacies ($1.2 M);
- *Acetaminophen Management* – Identify OGB members receiving more than the FDA recommended dose ($1.1 M);
- *Polypharmacy Management* – Identify OGB members receiving multiple prescriptions and determine if alternative options are available ($0.1 M);
- *Excluding Medical Foods* – The FDA does not have safety guidelines for these types of foods ($0.2 M).

LIVE BETTER LOUISIANA WELLNESS INITIATIVE

Although the costs for medical services will continue to increase, OGB is anticipating the Live Better Louisiana wellness initiative will assist in reducing future medical costs of the overall member population. This initiative encourages members to focus on preventive health including the use of the online personal health assessment tool and preventive onsite health checks. OGB anticipates this initiative will improve the OGB member future health outcomes that may result in reduced future medical expenditures of the overall program. Since the program's launch on May 30, 2014, there have been at least 280 members that have had a clinic check up of which 31% were identified as pre-hypertension and 14% were identified as pre-diabetic. OGB's remaining calendar year 2014 goal is to have 25% of the total member population screened.

HEALTH INSURANCE DEFINITIONS

Based upon research, the LFO has provided definitions of commonly used health insurance terms that are utilized throughout this document. The source of the prescription drug terms is from MedImpact's presentation to the OGB board on July 30, 2014. MedImpact is OGB's pharmacy benefit manager.

- ***Premium*** *– Amount of money a member pays monthly for health insurance.*
- ***Deductible*** *– Amount of money a member pays for eligible medical expenditures. After the deductible is met, the health plan pays 100% or the member shares the costs (coinsurance) with the health plan up to the out-of-pocket maximum (like the proposed OGB health plan options). The deductible is typically different for in-network and out-of-network providers. All new health plan options have different deductibles for in-network and out-of-network, excluding the Local/Local Plus health plans which have no out-of-network benefit at all.*
- ***Coinsurance*** *– Health cost sharing between the OGB member and the health plan. Cost share ranges included in the new OGB plan offerings range from 90/10 to 80/20, whereby the health plan pays either 90% or 80% of the medical service cost and the member pays the balance up to the out-of-pocket maximum.*
- ***Out-of-pocket Maximum*** *– The maximum amount of money an OGB member pays out-of-pocket for medical services in a health plan year. Under the OGB health plan offerings, co-pays, coinsurance and deductibles are all included in the out-of-pocket maximum calculation. The out-of-pocket maximum typically varies for in-network and out-of-network providers.*
- ***Health Savings Account (HSA)*** *– A savings account that is utilized in conjunction with a high deductible health insurance policy that allows an individual to save money tax-free in an account for medical expenses. Depending upon the employer policy, contributions are made to the account by the employer and employee and these funds can follow the employee.*
- ***Health Reimbursement Arrangement (HRA)*** *– An employer funded account that reimburses employees for out-of-pocket medical expenses. HRAs are notional accounts and the funds cannot follow the employee. In addition, only the employer can contribute to the account.*
- ***Generic Drugs*** *– Identical to a brand name drug in dosage, strength, effectiveness and safety.*
- ***Preferred Brand Drugs*** *– Drugs that have been on the market and do not have a generic equivalent available.*
- ***Non-preferred Brand Drugs*** *– Higher-cost medications that have recently come on the prescription drug market.*
- ***Specialty Medications*** *– Brand or generic drugs that cost over $600 and typically treat specific diseases such as Cancer, Multiple Sclerosis and Rheumatoid Arthritis.*
- ***Balanced Billing*** *– The practice of an out-of-network provider billing the health plan member the difference between the amount the health insurance plan pays (only if there is an out-of-network benefit) and the total medical services costs. If a health plan has an out-of-network benefit, it will only pay a percentage of what is known as "reasonable and customary" amount. If the health plan does not have an out-of-network benefit, the OGB member would be responsible for the entire medical costs of the out-of-network provider.*

In addition to the health and prescription drug changes, other topics of note related to OGB include the OGB Policy & Planning Board, the staff augmentation contract with Alvarez & Marsal (A&M) and the recently approved State Civil Service layoff plan.

OTHER OGB ISSUES

Office of Group Benefits Policy and Planning Board

Pursuant to R.S. 42:881, the OGB Policy & Planning Board shall review life and health benefit programs offered to eligible employees. In addition, the statute provides that the CEO shall submit any proposed changes to the life and health benefit programs to the board for review prior to the final adoption of the plan. The OGB board met on July 30, 2014 and the CEO presented to the OGB board the major health plan changes that will be effective on January 1, 2015 and the health plan changes that were effective August 1, 2014.

Although R.S. 42:802(B)(6) and R.S. 42:802(B)(7) authorize the OGB to establish premium rates and establish benefit plans under the direction of the commissioner of administration, it is unclear if the health plan and premium changes implemented by OGB in the middle of a plan year require official OGB board approval or if changing the health plan in the middle of the plan year is contradictory to the argument that the annual enrollment documents may be considered an annual contract between the health plan and the member. Also, pursuant to R.S. 42:881, the OGB shall submit a written report to the appropriate legislative oversight committees, including any comments and recommendations regarding modifications to proposed health plans. To date, this written report has not been completed. OGB's legislative oversight committees are the House Appropriations Committee and the Senate Finance Committee.

According to the Division of Administration (DOA), pursuant to federal law ***(26 CFR 54.9815-2715 – Summary of Benefits and Coverage and Uniform Glossary, paragraph (b) – Notice of Modification)*** if a group health plan makes any material modification, it must provide notice of the modification to enrollees no later than 60 days prior to the effective date change. OGB notified all plan members on June 3, 2014 of the August 1, 2014 health plan changes, which is within the 60-day requirement outlined in the federal law.

Note: *Prior to the July 30, 2014 OGB board meeting, the last OGB board meeting was held in February 2013.*

During that time frame, some of the significant changes that have been put in place include a health premium decrease (August 2013) and a health premium increase (July 2014).

A&M Staff Augmentation Consulting Services Contract
On December 19, 2013, the State entered into a $4.2 M contract with Alvarez & Marsal (A&M) for consulting services relative to finding efficiencies in state government, which resulted in the production of the Governmental Efficiencies Management Support (GEMS) Report. The contract was amended on January 27, 2014 increasing the contract by $794,678 for staff augmentation support of OGB's *Acceleration of Benefits Transformation Initiative*. This contract amendment increased the total contract value to $5 M. The *Acceleration of Benefits Transformation* are the A&M recommended changes included in the GEMS Report impacting the OGB including health plan and prescription drug changes as well as recommendations to completely reorganize the entire agency and implementing a wellness program that is anticipated to modify future health outcomes.

As was discussed by the LFO in the January 2014 edition of *Focus on the Fisc (Volume 2, Issue 7),* the A&M consulting contract included provisions that allow for staff augmentation services. The contract provides for augmentation services to be provided on an hourly basis depending upon the labor category of the work order and project. In May 2014, the DOA and A&M amended the $5 M contract again to include 5 various state agency work orders for staff augmentation services that total $2.4 M of which $199,752 is associated with the OGB. This contract amendment essentially extended the original OGB work order from ending on April 18, 2014 to ending on June 30, 2014. Based upon the contract amendment, the hourly rates charged to the state for OGB staff augmentation services range from $198/hour to $446/hour. Upon approval of the A&M contract amendment of $199,752, the total maximum amount the state will pay to A&M for staff augmentation services will be $994,430.

The specific tasks included in the contract amendment to be provided by A&M for OGB include:

- Supporting leadership changes to OGB including supporting the search for CEO and COO;
- Assisting interim CEO and COO by supporting other OGB executive roles;
- Establishing & supporting a vendor-related strategic timeline and assist in any key vendor transitions;
- Supporting benefit open enrollment;
- Supporting planning and execution for a agency reorganization and implementation of administrative efficiencies;
- Advising and implementing recommendations regarding change management and communication strategies and;
- Other staff support as requested regarding subject matter.

Layoff Plan Approved
The State Civil Service Commission officially approved the OGB layoff plan on July 28, 2014. According to documentation provided to the LFO by OGB, the layoff "is necessary because of a lack of work due to the change in function and structure of the OGB organization." The layoff plan will be effective September 1, 2014 and will impact 24 positions. The 24 positions being laid off impact the following OGB sections: Executive, Administration, Eligibility, Customer Service and Flexible Benefits. After the layoff, OGB will consist of 47 positions. The position reductions are associated with the overall reorganization of the agency, which is a portion of the OGB *Acceleration of Benefits Transformation*. For context, OGB's TO positions were 327 in FY 11.

STATE OF LOUISIANA
LEGISLATIVE FISCAL OFFICE
BATON ROUGE

John D. Carpenter
Legislative Fiscal Officer

Post Office Box 44097
Capitol Station
Baton Rouge, Louisiana 70804
Phone: 225.342.7233
Fax: 225.342.7243

TO: The Honorable James R. Fannin, Chairman Joint Legislative Committee on the Budget (JLCB)
The Honorable Jack Donahue, Vice Chairman Joint Legislative Committee on the Budget (JLCB)
Honorable Members of the Joint Legislative Committee on the Budget (JLCB)

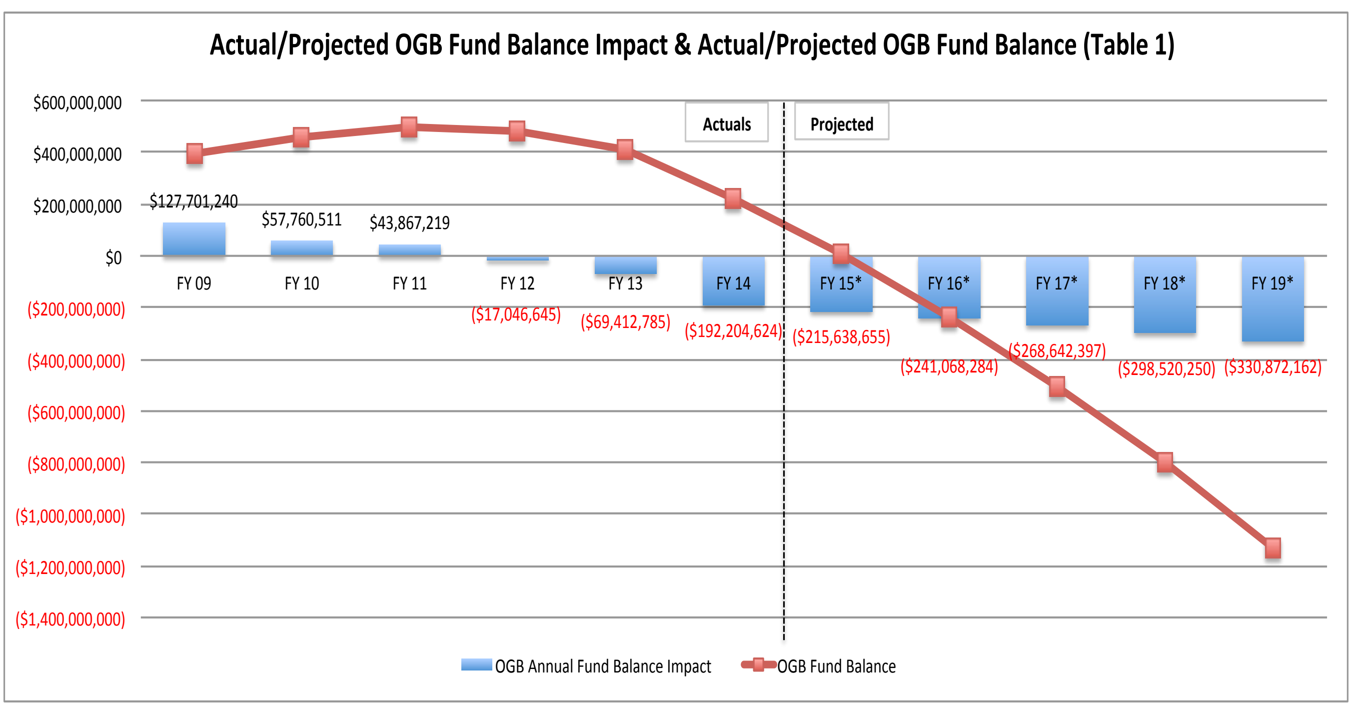
FROM: John D. Carpenter, Legislative Fiscal Officer
J. Travis McIlwain, Section Director

DATE: July 18, 2014

SUBJECT: Office of Group Benefits (OGB) Update

Pursuant to a request at the May 2014 Subcommittee Meeting of the JLCB, the LFO will be providing a monthly report on the status of the overall OGB fund balance to the JLCB. Based upon the latest OGB financial statements (as of May 2014), OGB's current fund balance is approximately $237.2 M, which is $176.2 M less (or 57%) than the fund balance as of June 30, 2013 ($413.4 M). In FY 14, OGB is expending an average of approximately $16.1 M more per month than actual per month revenue collections, which equates to utilizing a projected $192.2 M of OGB fund balance in FY 14 (See Table 1 below). To the extent this continues, OGB's fund balance may be $221.2 M at the end of FY 14 and could be $5.6 M at the end of FY 15. *<u>Note</u>: Without the 5% premium increase effective July 1, 2014, which is anticipated to generate $57.9 M of additional revenues, the anticipated ending year FY 15 fund balance could be a negative $50 M plus. These projections assume no material changes in OGB's expenditures, which on average increase approximately 6% annually (From FY 08 – FY 14).*

See Table 1 below, which shows the annual amount of fund balance OGB "generated" or "lived on" from FY 09 to FY 14 and projects the next 5 years based upon the **<u>current OGB expenditure trend (6% increase annually) and assuming revenues increase 5% annually</u>**. *Table 7 on Page 5 of this document shows OGB's ending year fund balance from FY 80 to FY 14.*

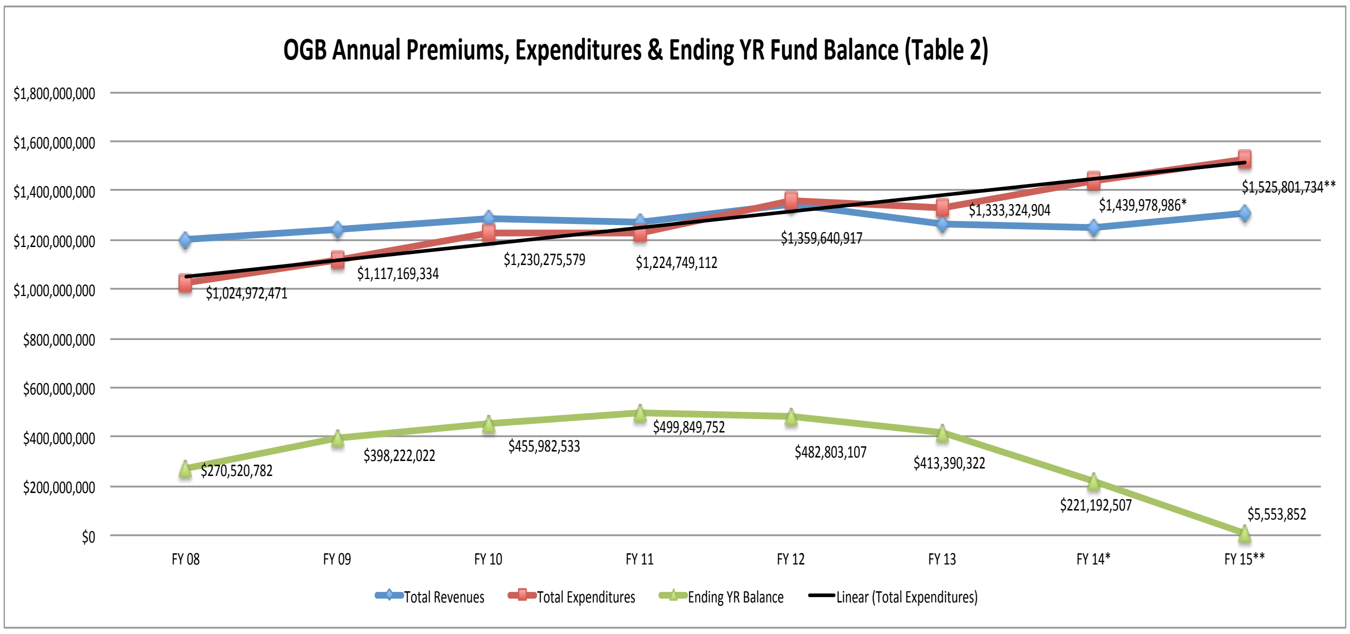


FY 15 – FY 19 OGB Fund Balance Impact & Fund Balance Projection is based upon historical OGB expenditures, which increase an average of 6% annually and assumes OGB revenues will increase 5% due to annual health insurance premium increases.* *<u>To the extent the OGB Administrative changes and Health Insurance Plan changes suggested by Alvarez & Marsal (A&M) result in overall programmatic expenditure savings, the subsequent fiscal year projections of the annual amount of fund balance utilized to run OGB illustrated above would likely be eliminated and/or significantly reduced depending upon the actual expenditure savings of such changes</u>.***

How did we get here?
Table 2 on the next page shows total OGB revenues, total OGB expenditures and the ending year OGB fund balance for the past 6 fiscal years with projected amounts for the remainder of FY 14 and all of FY 15.

Based upon Table 2, beginning in FY 12 OGB started to expend more than revenue collections. Thus, OGB began to live off its fund balance and has continued to do so through FY 14. There are 3 variables that play a role in understanding how OGB's fund balance decreased from $524.6 M in

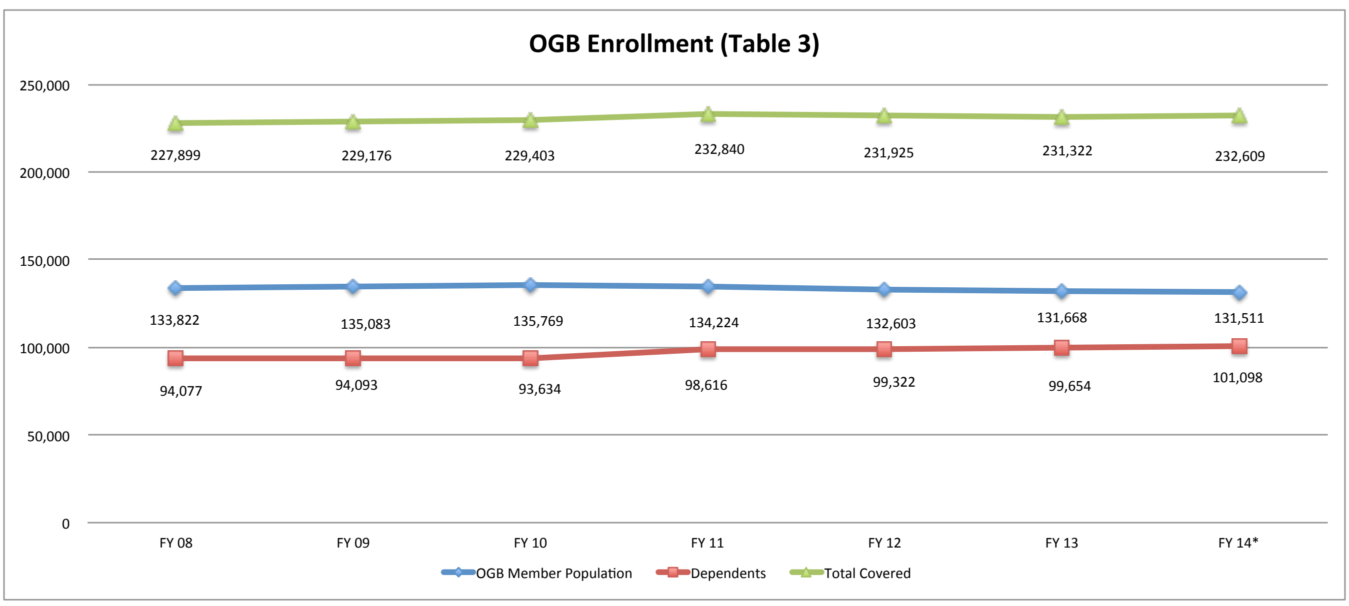
April 2011 (FY 11) to the current FY 14 projected ending year fund balance amount of $221.2 M. The variables include: *1.) OGB enrollment, 2.) Total OGB expenditures, 3.) Total OGB revenue collections. Based upon LFO analysis, overall revenue collections is the most significant factor contributing to the reduction in OGB's fund balance the past 3 fiscal years, which largely consist of health insurance premium collections*.



**FY 14 information is based upon the prior 11 months of actual revenues and expenditures.*
***FY 15 information is based upon expenditure and revenue trends from FY 08 – FY 14.*

OGB Enrollment

Based upon the information provided to the LFO by the OGB/DOA, the total number of OGB members paying premiums has remained relatively unchanged having only decreased 2% (or 2,311) from 133,822 total OGB premium paying members in FY 08 to 131,511 in FY 14. In addition, total OGB population covered, which includes all dependents and OGB members combined, has minimally increased from 227,899 in FY 08 to 232,609 in FY 14. Thus, OGB's enrollment changes have likely had little impact to the OGB fund balance, as the enrollment figures have remained static. See Table 3 below.



Total OGB Expenditures

Based upon the latest financial information provided to the LFO by the OGB/DOA, OGB's overall expenditures have grown an average of 6% per year. In fact, the trend line, which is included in Table 2 above, illustrates that FY 14 anticipated expenditures are extremely close to the anticipated trend over a 6-year period (FY 08 – FY 14). Thus, OGB's overall expenditures have consistently increased an average of 6% per year from FY 08 to FY 14 with expenditures increasing 10% and 11% in FY 10 and FY 12 and decreasing 1% and 2% in FY 11 and FY 13. *Note: For more specific information about TPA expenditures only, see Table 6 on page 4.*

% OGB Premium Rate Change (Table 4)	
FY 08	6.0%
FY 09	3.7%
FY 10	0.0%
FY 11	5.6%
FY 12*	8.1%
FY 13	-7.0%
FY 14	-1.8%
FY 15	5.0%

Total OGB Revenue Collections

Health insurance premiums (state share/employee share) represent the majority of OGB revenue collections. Based upon the latest financial information provided to the LFO by the OGB/DOA, OGB's health insurance premiums have increased only an average of 2.1% over the past 7 fiscal years. Table 4 illustrates the OGB health insurance premium rate changes from FY 08 to the current year (FY 15).

**Due to OGB changing from a state fiscal year to a calendar fiscal year, the health insurance premiums increased twice over a 12-month period during FY 12 (August 2011 by 5.6%, January 2012 by 5.0%). The 8.1% premium increase reflected in the table has been annualized to reflect the FY 12 % change in OGB health insurance premiums over a 12-month timeframe.*

Since FY 12, which is the first fiscal year that OGB expenses began to be higher than revenue collections since FY 06, OGB's expenditures have increased an average of 6% per year (from FY 12 to FY 14), while revenue collections have decreased 7% over the same timeframe. Of the 3 variables previously discussed, OGB revenue collections is the major variable that has contributed to the decline in the OGB fund balance over the past three years.

As has been stated before, including a premium decrease in the prior 2 fiscal years' budget allowed state agencies to lower their annual operating costs, thus allowing the state to indirectly utilize OGB's fund balance to support the FY 13 and FY 14 operating budgets. *Note: R.S. 42:854(C) provides that OGB's fund balance may not be utilized for the state's operating budget. "Notwithstanding any other provision of law to the contrary, any money received by or under the control of the Office of Group Benefits shall not be used, loaned, or borrowed by the state for cash flow purposes or any other purpose inconsistent with the purposes of or the proper administration of the Office of Group Benefits."*

Division of Administration/Office of Group Benefits – Going Forward

In order to mitigate and/or eliminate the current negative over spending "burn rate" of $16.1 M per month, along with a 5% premium increase for OGB members in FY 15, OGB is in the process of implementing a number of the A&M recommendations included in its report to Louisiana. Of the 72 recommendations that A&M believes will save the state $2.7 billion in expenditures (over 5 years), A&M's 2 recommendations associated with OGB equate to $1.1 billion (over 5 years) in expenditure savings. A&M breaks down the OGB recommendations into 2 categories: *administrative efficiency* and *health plan changes*. The specific recommendations and anticipated savings from the **A&M report** are as follows:

Administrative Efficiency

- $350,000 – Migration to eCommunications, which could save printing and postage costs, and leverage third-party vendor agreements to increase communication to members through third-party administrator mail distribution as opposed to OGB handling the traditional mailers.
- $????? – Utilize eEnrollment technology and require all state agencies to process dependent verification as opposed to OGB. This will require OGB to employ a new audit team or shift existing personnel into these roles or could result in a potential cost to state agencies depending upon the way this technology is implemented.
- $????? – Cease imaging services.
- $????? – Outsource to a third-party administrator for the administration of COBRA and Flexible Benefits.
- $680,000 – Move the OGB offices to the Claiborne building. OGB will likely have to pay Claiborne building rent. Thus the $680,000 projected rental savings by A&M will be less.
- $70,000 – Eliminate duplicative and unnecessary contracts.
- $1,144,000 – Utilize BCBS to pursue subrogation collections as opposed to being handled by DOA/OGB. According to the DOA, BCBS will now handle this function without an increase in the per member per month fee included in the existing TPA contract.
- $????? – OGB invest in an Interactive Voice Response for its customer service department.

Health Plan Changes

- $19,000,000 – Improvement health plan management.
- *$114,000,000 – Health Insurance Plan changes including reducing health benefits to OGB members and dependents.*

Table 5	Monthly	Annualized
OGB's Current Fund Balance "Burn Rate"	*($16,017,052)*	*($192,204,625)*
Administrative Changes (A&M #1)	$233,333	$2,800,000
Health Plan Mgmt (A&M #2)	$1,583,333	$19,000,000
Health Plan Changes (A&M #2)	$9,500,000	$114,000,000
5% Premium Increase	$4,825,000	$57,900,000
TOTAL Adjusted OGB Fund Balance Increase after Recommendations	**$124,615**	**$1,495,375**

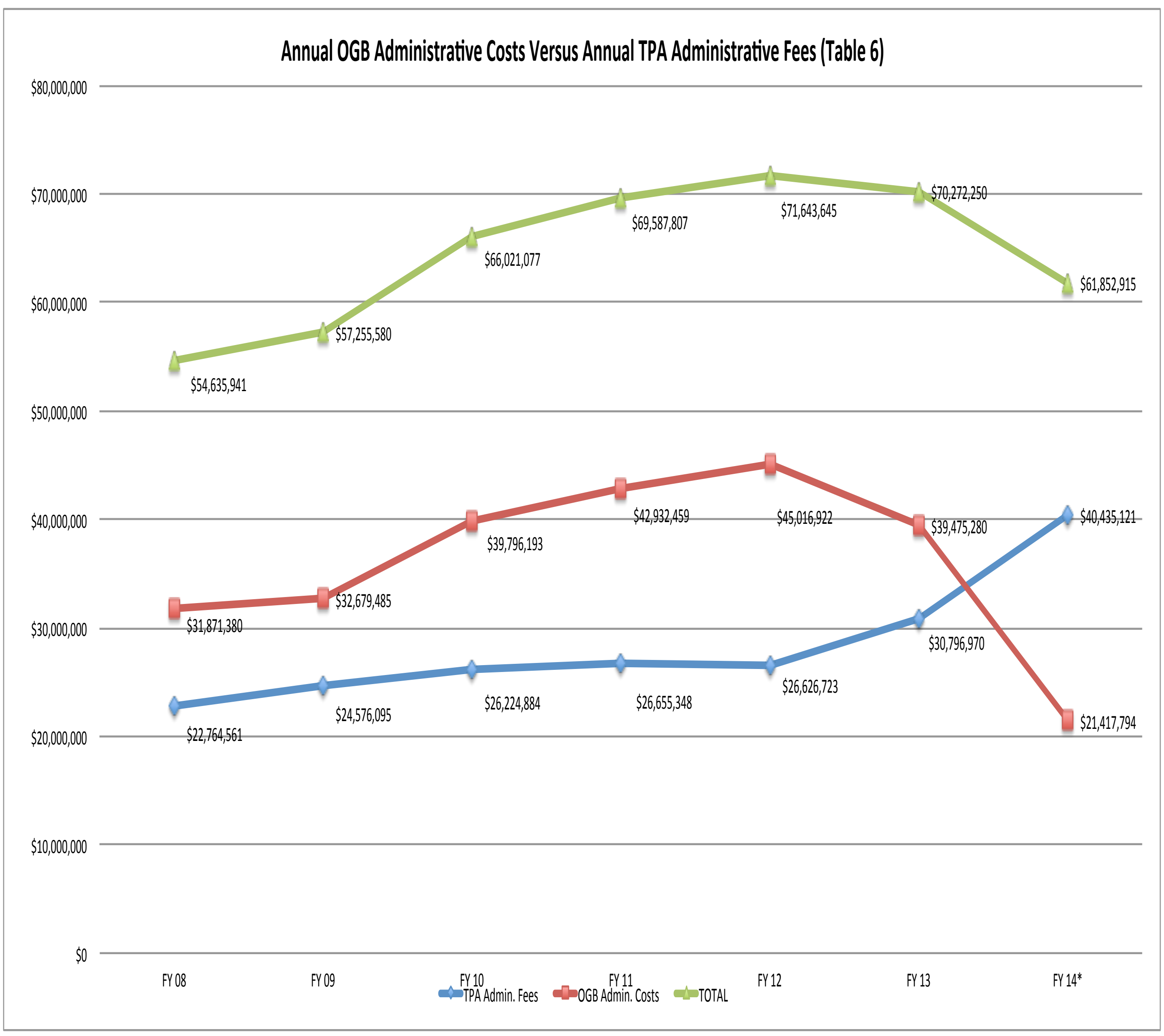
To the extent all A&M recommendations are implemented and result in the projected savings suggested in the A&M report, Table 5 is a monthly and annualized illustration of the potential impact to the OGB fund balance, which shows that OGB's current monthly negative "burn rate" of $16.1 M could be **eliminated**. ***However, the two major components of eliminating the negative burn rate are the increase in health premiums and reducing health plan benefits***. The major changes to the health plans will not be made known until annual enrollment for the 2015 plan year that begins in the Fall 2014. The basis for the illustration (Table 5) is the expenditure saving projections included in the A&M Report. **If these savings do not materialize, the OGB fund impact will be less and potentially could still be negative as it is today.**

*To the extent the A&M recommended health plan changes and administrative changes actually result in overall OGB cost savings, the **state fisc** would only experience an actual budgetary decrease if the insurance premiums (state share & employee share) are decreased, which will likely not occur. Thus, any expenditure savings that materialize as a result of these changes would only impact the OGB fund balance and not actually result in any state government budgetary savings*.

Potential OGB Expenditures As A Result Of Implementing Some A&M Recommendations
Some of the A&M recommendations listed on page 3 could result in additional one-time and/or recurring administrative expenditures depending upon the method utilized by OGB to implement the recommendations. The potential costs include:

- IT costs associated with implementing an eCommunications and eEnrollment process, which may result in one-time IT infrastructure costs and annual IT maintenance expenditures;
- One-time expenditure in the approximate amount of $5,000 for the Interactive Voice Response System (Telephone System);
- To the extent existing personnel and TO positions cannot be shifted to the OGB Audit Team, there may be additional personnel costs associated with this group of employees. OGB is currently undergoing reorganization that may result in existing employees taking on these duties.

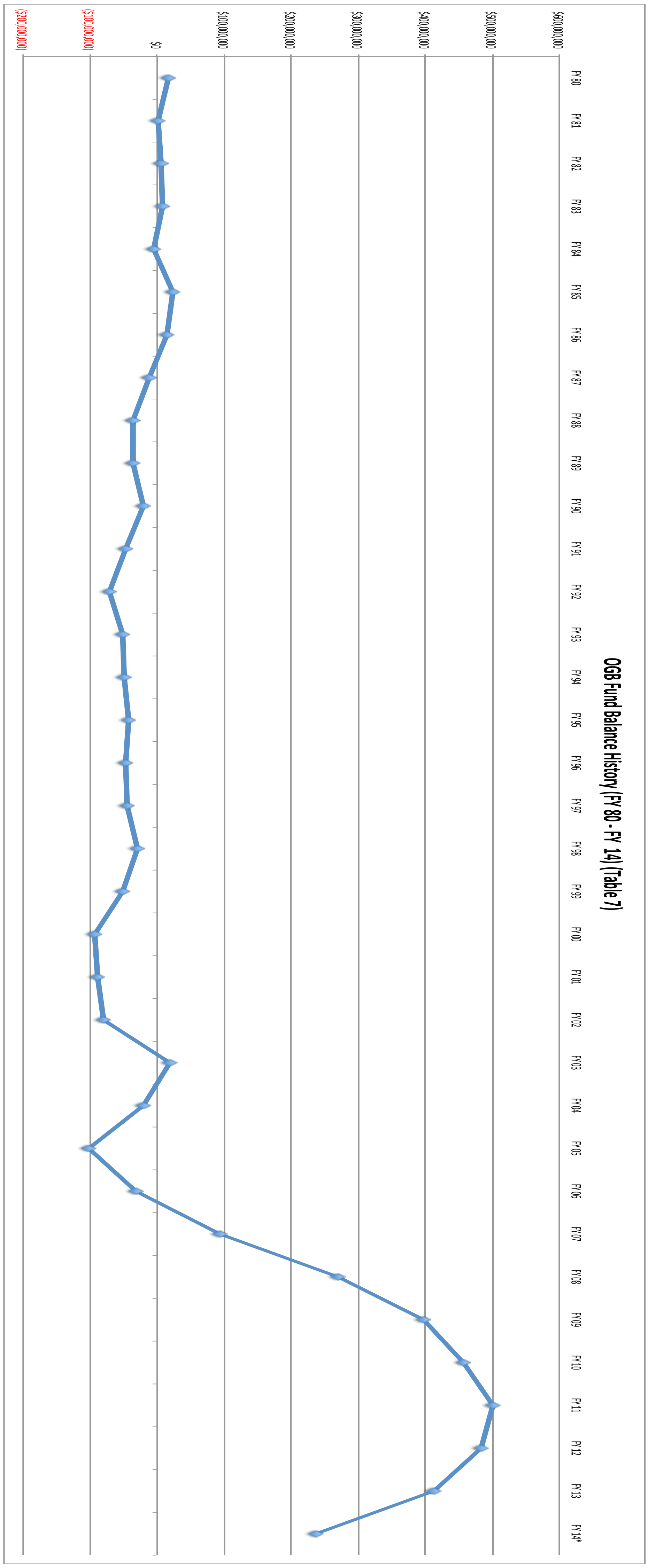
OGB Administrative Costs (OGB Administrative Costs/Third Party Administrator Costs)
Since FY 13, OGB's administrative cost started to shift from actual OGB TO position expenditures to more TPA expenditures. See Table 6 below for a history of such expenditures since FY 08. This is mainly due to Blue Cross Blue Shield (BCBS) taking over the administrative responsibilities of the PPO Plan, which used to be a health plan completely administered by OGB in-house personnel. In November 2012, the House Appropriations Committee and the Senate Finance Committee approved the TPA agreement between OGB and BCBS, which became effective in January 2013 for a 3-year contract to administer the PPO Plan, the Consumer Driven Plan, and to continue to administer the HMO Plan. Under the terms of the contract, the state will pay a monthly rate of $23.50 per member per month (PMPM) fee to BCBS for administrative services that mainly include health insurance network administration and paying medical claims. The contract provides for the PMPM to increase by $1 every year through the end of the contract, which is December 2015. The current PMPM rate is $24.50, which is increasing to $25.50 in January 2015, the last year of the contract term.



Note: To the extent OGB implements the A&M recommendation to utilize the services of a TPA for COBRA and Flexible Benefits, the OGB administrative costs will decrease even further and the TPA costs will increase in subsequent fiscal years.

**The FY 14 numbers include a projection for the month of June based upon the prior 11 months of overall administrative costs.*

OGB Fund Balance History
Table 7 below is a history of the OGB's ending year Fund Balance from FY 80 to FY 14 (through May 30, 2014).



**The FY 14 numbers include a projection for the month of June based upon the prior 11 months of overall administrative costs.*